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THE EPIDEMIOLOGY OF SCARLATINAL THROAT INFECTIONS SINE EXANTHEMATE*

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During an epidemic of scarlet fever among the nursing staff of the Presbyterian Hospital in 1924 and 1925, there occurred several cases of pharyngitis from which *Streptococcus scarlatinae* was isolated.[1] These scarlatinal infections of the throat, not accompanied by a rash, were similar clinically to concurrent throat infections caused by non-toxin-producing strains of *Streptococcus pyogenes,* and occurred among persons who had shown negative skin reactions with scarlatinal toxin previous to their illness. Such persons were presumably immune to scarlatinal infection. In another series of cases studied, prophylactic doses of scarlatinal antitoxin administered to contacts with scarlet fever had not only prevented scarlet fever but had prevented these scarlatinal throat infections sine exanthemate. From our observations it appeared that the immunity against *Streptococcus scarlatinae* was essentially antitoxic, and that antitoxin would prevent throat infection. Antitoxin in large amounts prevented both throat infection and the rash. Just sufficient antitoxin might be present in the blood stream and cells of a person to prevent the rash, but not to prevent the infection of the throat and the growth of streptococcus. If antitoxin were absent, or present in minimal quantities, infection would occur with the typical rash. A negative skin reaction with scarlatinal toxin apparently indicated the presence of antitoxin sufficient to prevent a rash, but not necessarily sufficient to prevent bacterial throat infection. What part an antibacterial immunity might play was not determined.

The completed study of these cases left three relevant questions undecided. 1. Could the same strain of *Streptococcus scarlatinae* cause typical scarlet fever in one person and a bacterial throat infection without a rash in another? It seemed possible that the two types of infection might be due to two types of strains that differed slightly in their invasive and toxin-producing properties. 2. Would scarlatinal antitoxin benefit the scarlatinal angina without the rash? 3. Could a person who had previously had scarlet fever have an angina without exanthem?

The circumstances surrounding the usual epidemics of scarlet fever are such that these questions cannot be readily answered from the previous study. The identification of the scarlatinal streptococcus is time consuming. To prove that the same strain is responsible for the infection of several persons, agglutinative serums must be prepared for each strain, and reciprocal absorption and agglutination done with all these serums and the strains in question. The amount of work involved prohibits such a detailed study of the large number of strains of streptococcus isolated. Nor has it seemed advisable to employ serum indiscriminately as a therapeutic measure in cases of streptococcus angina occurring during an epidemic. Usually during an epidemic of scarlet fever, especially if it occurs in the winter months, throat and wound infections with all types of hemolytic streptococcus are more prevalent. These difficulties have been met through the study of cases occurring in small groups in which extraneous contacts could be excluded with a fair degree of certainty.

CLINICAL AND BACTERIOLOGIC DATA

The groups of cases reported in this article were selected from cases of scarlatina observed outside institutions.[2] As we have stated in the preceding paragraphs, large epidemics or institutional cases are unsatisfactory for epidemiologic study. In one instance the possible sources of infection are too numerous and the bacteriologic identification of a large number of strains is impossible. In institutional cases the epidemiologic associations are lost. On the other hand, when cases of scarlet fever occur in families in which the possible sources of infection are limited in number, bacteriologic studies can be carried out. In the groups of cases presented in the following paragraphs, complete bacteriologic and epidemiologic observations were possible.

REPORT OF CASES

CASE GROUP 1.—The father of a child, aged 3 years, returned from an extended vacation with a mild pharyngitis and an acute rhinitis. His wife developed an acute pharyngitis and an antrum infection a few days later. She had little fever, but the throat infection was annoying and persistent. Before this angina had subsided, the daughter developed typical scarlet fever with the characteristic throat and exanthem. She responded promptly to therapeutic doses of antiscarlatinal serum. A culture of hemolytic streptococcus was taken from her throat (strain Ia in the table). The mother had had no obvious rash, but cultures from her nose and throat showed hemolytic streptococcus (strain Im). She showed a faintly positive cutaneous reaction with one skin-test dose of scarlatinal toxin. The angina subsided immediately following a prophylactic dose of scarlatinal antitoxin. None of these persons had previously had scarlet fever.

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1. Stevens, F. A., and Dochez, A. R.: The Occurrence of Throat Infections with Streptococcus Scarlatinae Without a Rash, J. A. M. A. **86**: 1110 (April 10) 1926. Stevens, F. A.: The Occurrence of Scarlet Fever Without a Rash During Epidemics, Proc. Soc. Exper. Biol. & Med. **23**: 346, 1926.

2. Stevens, F. A.: Unusual Instances of Infection with Streptococcus Scarlatinae, Proc. Soc. Exper. Biol. & Med. **23**: 348, 1926.

CASE GROUP 2.—A man, aged 40, who had not had scarlet fever, contracted an acute angina while on a business trip. He arrived home twenty-four hours after the onset with a temperature of 104 F. Three days later, his daughter developed scarlet fever. She had not been outside the nursery and had only been in contact with the mother and the nurse, neither of whom had had recent upper respiratory infections. Cultures from the child's throat showed hemolytic streptococcus (strain II a). The father had not yet recovered at this time. He had had no discernible rash; the intracutaneous toxin test was negative. Cultures from his throat showed two types of hemolytic streptococcus morphologically different (strains II f and II x).

CASE GROUP 3.—A woman was visiting a mother, aged 60, and her son, aged 25. During the first week of her visit she occasionally had a slightly sore throat in the evenings. At the end of the week, the son developed a severe angina with a temperature ranging between 100 and 101 F. The following day the visitor became acutely ill with a sore throat, and on Monday a typical scarlatiniform rash appeared. The mother became acutely ill with a pharyngitis on Tuesday. Her temperature was only 100 F., but the edema and pain were intense. The intracutaneous test (one skin test dose) with scarlatinal toxin was negative. Although she had no rash, a therapeutic dose of scarlatinal antitoxin was administered. Her throat symptoms were promptly relieved. The son showed a faintly positive intracutaneous test on the fourth day of his illness. No rash was observed, but during convalescence slight desquamation occurred on the hands. Strains of hemolytic streptococcus were isolated from throat cultures of the visitor (strain III a), of the son (strain III b), and from the mother (strain III m). The mother had previously had scarlet fever.

Toxin Production, Agglutination and Absorption of Agglutinin with Strains of Hemolytic Streptococcus from Scarlatina and Associated Contact Infections

Strain and Case	Heat Labile Toxin	Neutralized with Scarlatinal Anti-Toxin	Agglutination		Agglutinin Absorption			Therapeutic Result with Anti-toxin
			Serum	Result	Serum Absorbing Strain	Absorbed	Result	
I a	+	+	I a	+	I a	I a	+	+
			I m	+	I a	I m	+	
I m	+	+	I a	+	I m	I m	+	+
			I m	+	I m	I a	+	
II a	+	+	II a	+	II a	II a	+	+
			II f	+	II a	II f	+	
II f	+	+	II a	+	II f	II f	+	
			II f	+	II f	II a	+	
II x	—							
III a	+	+	III a	+	III a	III a	+	+
			III m	+	III a	III m	+	
III b	+	+	III b	+	III b	III b	+	
			III a	+	III b	III a	+	
III m	+	+	III m	+	III m	III m	+	+
			III a	+	III m	III a	+	

COMMENT

The strains of streptococcus from these cases of scarlet fever and associated contact infections were subjected to two serologic tests. Cultures of each strain in ordinary broth were filtered at the end of ninety-six hours' growth. The filtrates were tested for the presence of heat labile toxin which could be neutralized by scarlatinal antitoxic serum. Secondly, rabbits were immunized with each of the strains. The animals were bled at intervals during the immunization, and reciprocal agglutination and agglutinin absorption tests were undertaken with the serums and the corresponding strains isolated from each group of cases. The serums for these reactions were chosen from the series of bleedings from each immune rabbit, so that all the serums employed in the tests involving strains from a group of cases were of approximately equivalent titer. The strains were first agglutinated with all the serums corresponding to the strains in each group. The minimal dose required to absorb the homologous agglutinin was next determined for each serum and its homologous strain. This dose of each strain was then employed to absorb the agglutinin from other serums of the group for their corresponding strains. Other details of agglutination and absorption have been described elsewhere.[3] The data have been arranged in the accompanying table.

An analysis of these data shows that the strains in each group of cases are identical. This conclusion is based on the fact that all the strains of each group are capable of absorbing the agglutinin from serums prepared with the other strains. Complete absorption did not occur with the serums and strains of different groups. We should anticipate that a scarlatinal agglutinative serum would be absorbed by any scarlatinal strain and by certain strains of *Streptococcus erysipelatis* and *pyogenes*.[4] Unless the strain employed in preparing the serum and the strain employed in absorption were similar or identical, the serum so absorbed would still agglutinate the strain corresponding to the serum, but would not agglutinate other scarlatinal strains. In these absorption tests, absorption was complete and reciprocal with the serums and strains of each group of cases. Krumwiede[5] believes that the reciprocal absorption tests are necessary to establish the perfect identity of various strains of the colon-typhoid group of bacteria. Since it appears that the agglutinogen of hemolytic streptococcus resembles the agglutinative antigen of this group of bacteria in certain respects,[6] we believe that these absorption tests satisfy all reasonable requirements for the absolute identity of the strains in question.

In a series of agglutination tests with *Streptococcus scarlatinae*, Williams[7] found that identical strains might be isolated from the throats of patients with scarlatina occurring in the same family, so it is not surprising that the strains within each of these groups of cases are identical. With the exception of one strain in group II, all the strains produced scarlatinal toxin. The similarity of these strains answers the first of the questions asked at the beginning of this report. The same strain of *Streptococcus scarlatinae* may cause either scarlet fever or a scarlatinal throat infection sine exanthemate. Both types of cases are infectious, and the type of infection with any one strain must depend on the immune reaction of the person infected. On the other hand, strains of *Streptococcus scarlatinae* vary in their invasiveness and their ability to produce toxin, so the type of reaction must depend to a certain extent on the virulence of the strain.

Antitoxic serum was employed in two cases of streptococcus angina with satisfactory therapeutic results. In one instance, serum was administered as a prophylactic, and the therapeutic result substantiated the later bacteriologic diagnosis of scarlatina sine exanthemate. In the second case, the antitoxin was administered as

3. Stevens, F. A., and Dochez, A. R.: Antigenic Relationships Between Strains of Streptococcus from Scarlet Fever and Erysipelas, J. Exper. Med. **43**: 379 (March) 1926. Antigenic Relationships Between Strains of the Scarlatinal and Erysipelas Groups of Hemolytic Streptococci, ibid., to be published. Meleney, F. L., and Stevens, F. A.: Postoperative Hemolytic Streptococcus Wound Infections and Their Relation to Hemolytic Streptococcus Carriers Among the Operative Personnel, Surg. Gynec. Obst. **43**: 338 (Sept.) 1926.

4. Stevens and Dochez (Footnote 3, first and second references).

5. Krumwiede, C.; Cooper, G., and Provost, D. J.: Agglutinin Absorption, J. Immunol. **10**: 55 (Jan.) 1925.

6. Stevens and Dochez (footnote 3, second reference).

7. Williams, A. W., and Hussey, H. D.: Serologic Groups Among Hemolytic Streptococci from Scarlatina, Abstr. Bacteriol. **8**: 27, 1924.

a therapeutic measure on account of the close contact with a case of clinical scarlet fever. The therapeutic result in these cases was to be anticipated from the excellent effect of serum on the angina occurring in scarlet fever. We conclude that the administration of serum is justifiable in cases of severe streptococcus angina developing among scarlatinal contacts, provided there is sufficient basis for concluding that they are scarlatinal infections.

In the study of the epidemic at the Presbyterian Hospital, we found cases without rash only among persons with negative skin reactions. Among the cases reported here, two scarlatinal anginas occurred in persons with faintly positive Dick tests. Since one of these patients later showed slight desquamation, he probably had a very mild rash. One of the cases of scarlatinal angina occurred in a person who had previously had scarlet fever and who showed a negative skin test.

CONCLUSIONS

1. The same strain of *Streptococcus scarlatinae* may cause clinical scarlet fever or scarlatina sine exanthemate.

2. Cases of scarlatinal angina are infectious.

3. Scarlatinal antitoxin is an efficient therapeutic agent in scarlatinal throat infections without a rash.

4. Throat infections with *Streptococcus scarlatinae* may occur in persons who have previously had scarlet fever.

PREVENTION OF MEASLES BY IMMUNE GOAT SERUM*

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In a previous article[1] we showed that the serum of a goat convalescing from a reaction produced by the inoculation of green-producing measles diplococci protected rabbits against a subsequent injection of infective material from measles. The rabbits injected with normal goat serum and those untreated showed some or all of the characteristics of measles in rabbits—a rise of temperature, Koplik spots and a rash. Convalescent goat serum protected human beings against measles as effectively as convalescent human measles serum when injected on the first and second days after exposure to measles. By intracutaneous tests in normal rabbits, the serum of goats injected with diplococci from measles as well as convalescent human measles serum was shown to neutralize the action of killed measles diplococci, while serum of normal goats had no such effect.

Since convalescent goat serum appeared to protect against measles only if given on the first two days after exposure, we thought that better protection might be afforded with the serum of more highly immunized goats. Two goats were now immunized, first with killed measles diplococci, later with living organisms and their filtrates. Three strains were used, one from the blood, one from the nose and one from the throat.

The organisms were grown in 1 per cent dextrose broth twenty-four hours, the cultures centrifugalized and the cocci suspended in salt solution. Later, broth cultures of the cocci and also filtrates of six day cultures, in 1 per cent sheep blood dextrose broth were injected. Small doses were given at first, but by the end of three months the growth from 200 cc. of broth was injected into each goat. All injections were made intravenously. Over a period of four months, injections were given in series daily on three successive days separated by a four day interval of rest. At the end of four months, injections were made once a week. After the first few doses there was not much rise in temperature, although the goats often appeared sick after the injection. At the end of three months, the serum of the two goats contained about the same amount of antibodies. The serum agglutinated the three immunizing strains at from 1:2,500 to 1:5,000, and contained from fourteen to twenty-four times more opsonins than normal goat serum. After the first three months of immunization, the antibody content of the serum reached its height and then fell slightly and remained about stationary.

By intracutaneous tests in normal rabbits, the serum was found to neutralize the action of both killed measles diplococci (intracellular toxin) and filtrates from measles diplococcus cultures (extracellular toxin), while normal goat serum had no such effect.

The power of immune goat serum to prevent measles in shaved rabbits was tested. Five cubic centimeters of serum was injected subcutaneously into one rabbit just before, and into another rabbit two days after intratracheal injection of 5 cc. of the washings of the nose and throat from a child with Koplik spots and the beginning of a measles rash. These two rabbits showed no signs of measles, while the control rabbit receiving the same measles washings and no serum was slightly sick and showed a rise of temperature from the fourteenth to eighteenth days after inoculation, and at this time a well marked rash followed by desquamation.

The serum was also tested on white mice to determine its protective power against a freshly isolated measles diplococcus. The three strains of cocci used in immunization had been isolated several years previously and were not now virulent for mice. Mixtures of serum and coccus suspensions were injected intraperitoneally. One fifth of a twenty-four hour growth of cocci on blood agar suspended in salt solution was found to be the least amount that would kill a normal mouse in twenty-four hours. Broth cultures were less virulent. Mice receiving mixtures of normal goat serum and cocci or salt solution and cocci died within twenty-four hours. Mice receiving immune goat serum and cocci survived from one week to one month. Five-tenths cubic centimeter of serum was generally necessary to protect, but with some serums 0.2 cc. was sufficient.

The intracutaneous injection of 1 cc. of immune goat serum into two persons with Koplik spots, but before the appearance of any rash, almost completely prevented the development of the measles rash over an area of about 2 cm. around the site of injection. Debré, Bonnet and Broca[2] injected subcutaneously from 1 to 5 cc. of convalescent human measles serum at the beginning of the period of invasion just as the catarrhal symptoms and Koplik spots appeared, but before the beginning of any eruption and found that when the rash appeared there was inhibition about the point of injection varying in size with the amount of serum injected. Normal

* From the John McCormick Institute for Infectious Diseases and the Children's Memorial Hospital.

1. Tunnicliff, Ruth; and Hoyne, A. L.: Further Studies on a Diplococcus from Measles: Prevention of Measles by Immune Goat Serum, J. Infect. Dis. **38**: 48 (Jan.) 1926.

2. Debré, R.; Bonnet, H., and Broca, R.: Sur l'inhibition locale de l'éruption morbilleuse par l'injection préalable de sérum de convalescent, Compt. rend. Soc. de biol. **89**: 70 (June) 1923.

goat and human serums failed to produce any inhibition.

Tricresol (0.3 per cent) was added to the immune goat serum.

The serum from the immunized goats was given subcutaneously or intramuscularly, generally in 5 cc. doses, to children and a few nurses who gave a negative history of measles and were at this time exposed definitely to the disease.

Hoyne and Gasul [3] used this immune goat serum in thirty-nine children over 6 months of age, and concluded that if the serum was administered not later than the fifth day of exposure (counting the date of onset as the first day of the disease) protection seemed assured in about 90 per cent. Those who received serum early, but were not wholly protected, developed an attenuated form of the disease. There were no deaths or complications in any of the patients who developed measles after getting serum, while among the nine contacts who received no serum, eight contracted measles and two of these died. They found that immunity lasted from two to four weeks; in some instances, longer. The serum produced no bad effects regardless of the age or physical condition of the child. Serum rashes occurred in 12 per cent of cases and persisted one or two days.

The present report gives the results of using immune goat serum in 105 additional persons, with a negative history of measles, but subjected to a definite exposure to the disease. Serum was given to ten other persons, but their history of exposure was doubtful. Most of the persons receiving serum were in hospitals. The greatest number of tests with the serum were made by Dr. Kenneth D. Blackfan of Boston, Dr. M. G. Peterman of Milwaukee, and Dr. Clifford G. Grulee and Dr. H. William Elghammer of Chicago.

It was not always possible to get a definite history of the day of exposure to measles. As far as possible, we used here the method of Zingher [4] in estimating the day of exposure of children in contact with measles patients in wards. The first day of the appearance of the rash is considered the fourth day of the disease.

Of thirty-three persons 1 year old or older who, as nearly as we could determine, received serum from one to three days after exposure to measles, one developed the disease. Out of nine children receiving serum on the fourth day after exposure, five contracted measles; while eighteen persons who received serum on the fifth day or later after exposure, and forty-two contacts equally exposed who received no serum all developed the disease, as shown in the accompanying table.

Data Concerning Ninety-Four Persons, Aged 1 Year or More, Who Were Exposed to Measles

		Developed Measles
Injected with immune goat serum:		
On first, second or third day after exposure	33	1
On fourth day after exposure	9	5
Later than fourth day after exposure	18	18
Not injected with immune goat serum	42	42

Since young infants, especially if breast fed, are generally considered immune to measles, children under 1 year of age who received serum are considered separately. Eleven infants getting serum after the fourth day after exposure all developed measles. Two of these were 4 and 5 months old, the ages of the others ranging from 6 to 10 months. Four infants, 5, 6, 7 and 8 months old, showed no signs of measles after the first exposure, but developed the disease when exposed one month later. One infant, getting serum on the fourth day after exposure, contracted the disease nineteen days later, suggesting a delayed incubation period. Thirty-three infants, ten over 6 months old, who were given serum within the first four days after exposure, showed no signs of measles. Thirteen of these infants were bottle fed.

Of the fifty-two persons over 6 months of age receiving serum before the fifth day after exposure 89 per cent were protected. These figures agree with those of Hoyne and Gasul, who made their estimation in this way.

Measles in children receiving serum was often very mild, but no modification of the disease as described by Zingher [4] and Weaver and Crooks [5] was observed.

There were only a few instances of reaction to the goat serum; three of these were mild, eleven severe. Of the first ten persons who were given serum, marked local reactions occurred in nine and a rise of temperature in four. It is impossible to explain these severe reactions, since none were observed in twenty other persons treated with the same lot of serum.

It will be necessary to use serum of animals immunized with measles cocci in a large number of cases before definite conclusions can be drawn as to its value. These experiments indicate that a dose larger than 5 cc. should be used if given on or later than the fourth day after exposure. It is possible that concentrated serum will give better protection. Some immune goat serum has been concentrated by Dr. P. G. Heinemann of Cook Laboratories, Inc., and the results with this serum will be reported later.

SUMMARY

1. Goats have been immunized with green-producing measles diplococci and their filtrates, and an antibacterial and antitoxic serum was produced.

2. From 4 to 6 cc. of immune goat serum was given to children 1 year old or older and to a few nurses, with a negative history of measles, after a definite exposure to measles. All persons who did not receive serum, and all who received serum five days or more after exposure, developed measles. Goat serum prevented measles in 45 per cent of persons who received serum on the fourth day after contact with measles patients, and in 97 per cent of those who received it within the first three days after exposure.

3. All infants under 1 year of age who received serum after the fourth day after exposure developed measles. Ninety-eight per cent of infants given serum within the first four days after exposure failed to show any signs of the disease.

4. Reactions to the goat serum were observed in 12 per cent of those injected.

5. Although the duration of passive immunity with immune goat serum, as with human convalescent measles serum, is only a few weeks, the serum appears to be useful in preventing measles in very young and sick children, and in stopping epidemics in institutions where the inconvenience of an epidemic is great and the mortality may be high.

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3. Hoyne, A. L., and Gasul, B. M.: Measles Prophylaxis: Report of the Use of Immune Goat Serum, J. A. M. A. **87**: 1185 (Oct.) 1926.

4. Zingher, Abraham: Convalescent Whole Blood, Plasma and Serum in Prophylaxis of Measles, J. A. M. A. **82**: 1180 (April) 1924.

5. Weaver, G. H., and Crooks, T. T.: Further Observations on the Use of Convalescent Serum in the Prophylaxis of Measles, Wisconsin M. J. **23**: 555 (March) 1925.

STREPTOCOCCUS ERYSIPELATIS TOXIN AND ANTITOXIN*

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We attempted to apply the Schulz-Charlton extinction phenomenon to erysipelas, using serum obtained from convalescent erysipelas patients. From 0.5 to 1 cc. was injected intradermally in the central portion of the zone of active inflammation, or in the advancing, raised, red border. Readings were made after six, twelve, eighteen and twenty-four hours. The results of fifty-five cases showed that distinct blanching, such as is produced in scarlet fever with scarlet fever convalescent serum, does not occur in erysipelas with any degree of consistency. Attempts to cause blanching of erysipelas lesions by means of 1 cc. of concentrated scarlet fever antitoxin (Dick) failed in all of ten trials.

Although distinct localized blanching did not result from the inoculation of convalescent erysipelas serum, one was led to conclude that a beneficial effect of some degree followed its introduction into the skin. For example, quite frequently when the injection was made at an advancing margin, the lesion would halt at the site of inoculation, but progress elsewhere. The impression gained was that, although unable to obliterate an infiltrated inflammatory zone, the convalescent serum did exert some influence to combat the effect of the organisms or their products.

In order to determine the validity of the impression that the convalescent serum contained immune bodies, we employed the following method of study: We tested the skin reaction of erysipelas patients to a sterile filtrate of a pure culture of *Streptococcus erysipelatis* obtained from a bleb of a case of facial erysipelas, prepared after the method employed by the Dicks[1] for scarlet fever toxin.

We were able to demonstrate a susceptibility of erysipelas patients to small doses of the toxic filtrate during the early and active stages of the disease, confirming in this regard Birkhaug's[2] observations. As the disease defervesced, the skin reactions with the same amounts and concentrations of the filtrate became progressively weaker or disappeared entirely. For example, patient L. K., Aug. 6, 1925, at the height of the disease, gave strongly positive reactions which became less and less marked on repetition of the tests, August 8, 13 and 18. Patient E. N., who reacted strongly to the first inoculation, gave a negative result in a subsequent test performed forty-eight hours later. Birkhaug[2] records similar results with his erysipelas patients. We were dealing, obviously, with the production of immune bodies which were responsible for the local effect of the convalescent serum noted by us in the attempt to produce blanching of the erysipelous lesion.

Since the filtrate we were employing resembled in its properties the Dicks' scarlet fever toxin in regard to the skin reactions evoked and in its resistance to heat, we suspected that we might be dealing with a true toxin. If this were the case, the filtrate (toxin) should, when injected into animals or man, be capable of producing within the body a neutralizing substance (antitoxin).

We chose two patients, favorable subjects for nonspecific protein therapy, in whom the skin reactions showed a high degree of susceptibility to both scarlet fever and erysipelas filtrates. Before the immunization process was begun, the two patients were bled and the neutralization powers of the serums tested in the following manner: Equal quantities of diluted filtrate (1:100) and patient's serum were mixed, incubated at 37.5 C. for one hour, and injected in amounts of 0.2 cc. intradermally, following which readings were made at twenty-four, thirty-six and forty-eight hours. In both patients neither the erysipelas nor the scarlet fever filtrate was neutralized by the patients' serums, as indicated by the positive reactions that occurred as a result of the inoculations.

The two patients were immunized by injections of erysipelas sterile filtrate (toxin) at first intradermally, and later subcutaneously, beginning with 0.1 cc. of 1:100 dilution until 15 cc. of the undiluted filtrate was administered at one time. Injections were given early in the course of immunization twice a week, later at more frequent intervals, even as often as every twenty-four to forty-eight hours, according to the resulting reactions. The immunity produced was indicated by the disappearance of general and local discomfort, as well as by the decreasing sensitiveness to increasing skin test doses. From eight to ten days after the last inoculation, these patients were bled, and the serum was collected and kept in the refrigerator. We shall refer to this immune serum as "erysipelas antitoxin."

It was deemed advisable at this point to determine the relative protective value of the artificially produced human immune serum (antitoxin) as compared with convalescent serum obtained from erysipelas patients. One mode of attack afforded us was the blanching test, and a second method neutralization experiments.

Early in our studies we were convinced of the greater potency of the antitoxin, for we were able to elicit the extinction phenomenon in erysipelous lesions in 50 per cent of the attempts made, whereas the convalescent serum in similar amounts failed in every case, as previously stated, to produce blanching.

TABLE 1.—*Preliminary Skin Tests*

Toxin Injected	(*a*) Erysipelas			(*b*) Scarlet Fever		
Dilutions	1:10	1:100	1:1,000	1:10	1:100	1:1,000
Total tested	86	86	86	86	86	86
Number positive	47	32	9	72	63	19
Percentage positive	54.6	37.2	10.4	83.7	73.2	22.0

For our neutralization tests, we chose at random eighty-six medical patients on whom we performed preliminary skin tests with various dilutions of erysipelas and scarlet fever toxin (table 1), using as controls killed and noninoculated filtrate. It will be seen from the table (1 *a*) that forty-seven of the eighty-six persons tested gave a positive reaction to the erysipelas toxin when used in the dilution of 1:10. In thirty-eight of these forty-seven positive reactions, neutralization tests were performed with equal quantities of undiluted erysipelas toxin and undiluted erysipelas antitoxin, prepared by incubation as described, and injected in amounts of 0.2 cc. (table 2 *a*). The results show complete neutralization of the undiluted toxin by its homologous antitoxin in practically three fourths of the

* From the Department of Medicine of the University of Illinois College of Medicine, and the Cook County Hospital.

1. Dick, G. F., and Dick, Gladys H.: A Method of Recognizing Scarlet Fever Streptococci by Means of Specific Toxin Production, J. A. M. A. **84**: 802-803 (March 14) 1925.

2. Birkhaug, K. E.: Studies on the Biology of Streptococcus Erysipelatis: IV. Toxin Production of the Streptococcus Erysipelatis, Proc. Soc. Exper. Biol. & Med. **23**: 201-204 (Dec.) 1925.

cases (73.7 per cent). The same experiment performed in twenty-one instances, convalescent erysipelas serum (table 2 *b*) being used in place of the antitoxin, resulted in complete neutralization of only 38.1 per cent of the cases. Here again we observed a greater protective power of the antitoxin as contrasted with that of the convalescent serum. It was noted in subsequent tests that in using a dilution of 1:100 instead of the undiluted toxin, a much higher percentage of neutralization was obtained with both serums, the antitoxin, however, being far more effective than the convalescent serum.

TABLE 2.—*Neutralization Skin Tests*

Equal Quantities of	Total Tested	Neutralization					
		Complete		Partial		Absent	
		No.	%	No.	%	No.	%
(*a*)							
Erysipelas toxin							
Erysipelas antitoxin	38	28	73.7	4	10.5	6	15.8
(*b*)							
Erysipelas toxin							
Erysipelas convalescent serum	21	8	38.1	2	9.5	11	52.4
(*c*)							
Erysipelas toxin							
Scarlet fever antitoxin	22	6	27.3	2	9.1	14	63.6
(*d*)							
Scarlet fever toxin							
Erysipelas antitoxin	62	33	53.3	25	40.3	4	6.4
(*e*)							
Scarlet fever toxin							
Erysipelas convalescent serum	29	7	24.1	13	44.8	9	31.1

The protective value of our immune serum obtained by the injection of filtrate appears to compare with that of the antierysipelas serums obtained from animals by other workers with injections of cultures of the organisms. Rivers [3] produced an immune serum by intracutaneous inoculations of the living organisms into rabbits, and, together with Tillett,[4] demonstrated its protective properties in local passive immunity experiments. Birkhaug [5] produced an effective antierysipelas serum by injecting into the rabbit and the donkey hemolytic streptococci obtained from erysipelas cases. Judging from his results in blanching and neutralization studies, the impression gained is that our antitoxin is similar in its action to Birkhaug's antierysipelas serum. It would be of interest to determine the relative potency of the two immune serums obtained by the injection of organisms and sterile filtrate (toxin), respectively.

In order to determine the specificity of the erysipelas and scarlet fever toxins and serums, we employed neutralization tests, using three different combinations (table 2 *c*, *d* and *e*). Of twenty-two patients who gave a positive skin reaction to 1:10 erysipelas toxin (table 1 *a*), 27.3 per cent failed to react when equal quantities of undiluted erysipelas toxin and scarlet fever antitoxin (Dick) were incubated and injected into the skin (table 2 *c*). The complete neutralization of the heterologous serum in practically one fourth of the cases would indicate a lack of absolute specificity.

In our examination of sixty-two of the seventy-two patients yielding a positive skin reaction with scarlet fever filtrate in the dilution of 1:10 (table 1 *b*), we found that in 53.3 per cent of the cases tested the erysipelas antitoxin completely neutralized equal quantities of undiluted scarlet fever toxin (table 2 *d*). Here, again, a toxin was rendered innocuous by a heterologous serum. Of twenty-nine patients of the same seventy-two found susceptible to 1:10 scarlet fever toxin (table 1 *b*), 24.1 per cent showed complete neutralization of the undiluted scarlet toxin by equal quantities of convalescent erysipelas serum (table 3 *e*). In addition to the occurrence of a cross-neutralization in this group of cases, it is to be noted that the heterologous convalescent serum was far less potent in the neutralization of the scarlet fever toxin than the artificially produced heterologous human serum.

The question of type specificity within the hemolytic streptococcus group, together with the literature on the subject, has been treated recently by Birkhaug.[5] In his own work he was able to demonstrate by means of agglutination and agglutinin absorption tests that thirty-one of thirty-four, or 91.2 per cent, of erysipelas strains of hemolytic streptococci fell antigenically into one group, and could therefore be differentiated serologically from hemolytic streptococci isolated from scarlet fever and from miscellaneous streptococcic infections such as cellulitis and empyema. He offers further convincing evidence in support of his contention, but one must conclude from his results that the specificity, though striking, is only a relative one.

The results obtained in further studies on neutralization undertaken in groups of erysipelas, scarlet fever and surgical patients, with materials from the same bacterial strains as in the tables recorded above, show approximately the same percentages of cross-reactions. The lack of specificity demonstrated throughout our work may, in the light of the observations of others, be accounted for by the fact that throughout our studies we used, in order to obtain comparative results, only two strains of *Streptococcus erysipelatis*, and only one strain of the streptococcus of scarlet fever. It is conceivable that all the strains we employed belong in the small group of nonspecific hemolytic streptococci which Birkhaug and others encountered in classifications on the basis of agglutination, immunity and other biologic tests.

CONCLUSIONS

1. The sterile toxic filtrate of a broth culture of *Streptococcus erysipelatis* possesses the properties of a true toxin.

2. The erysipelas toxin is capable, when injected into man, of provoking the formation of a neutralizing substance (antitoxin).

3. The artificially produced immune serum (antitoxin) has a greater potency than convalescent erysipelas serum.

4. The antitoxin produced by injections of toxin alone seems to compare in its protective qualities with the antierysipelas serums obtained by others from animals by the injection of organisms.

5. The hemolytic streptococci of erysipelas and scarlet fever are not biologically absolutely specific.

3. Rivers, T. M.: Skin Infection of Rabbits with Hemolytic Streptococci Isolated from a Patient with Erysipelas, J. Exper. Med. **41**: 179-184 (Feb.) 1925.

4. Rivers, T. M., and Tillett, W. S.: Local Passive Immunity in the Skin of Rabbits to Infection with (1) A Filtrable Virus, and (2) Hemolytic Streptococci, J. Exper. Med. **41**: 185-194 (Feb.) 1925.

5. Birkhaug, K. E.: Erysipelas: V. Observations on the Etiology and Treatment with Erysipelas Antistreptococcic Serum, J. A. M. A. **86**: 1411-1417 (May 8) 1926.

Economics of Medical Practice.—With the expansion and rapid development of medicine, there are more opportunities and varied openings than ever before. Secondly, apart from accidents, illness and grave misconduct, a competence or living wage is within the reach of practically all qualified medical men who choose to work. To enter on the physic line as a means of livelihood is justified by the results, but as a path to great material prosperity the way is long, treacherous, and may land the traveler in a slough of disappointment. —Rolleston, Humphry: *Lancet* **2**:737 (Oct. 9) 1926.

STREPTOCOCCUS VACCINE AS A PREVENTIVE MEASURE FOR SCARLET FEVER

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I began experiments with streptococcus vaccine at the suggestion of the late G. N. Gabritchevski[1] in January, 1906. At first, vaccination was done only in a hospital for the purpose of studying the clinical picture of the postvaccinal sickness, but it was later transferred to a dispensary and finally, done locally in those villages in which the first cases of scarlet fever had been reported.

The vaccine was prepared by the bacteriologic institute of the Moscow University.

To sum up all the vaccinations carried in the lapse of a year since the end of January, 1906, I may state that there were in all 1,187 vaccinations on 767 persons, 149 of whom were vaccinated thrice; 106, twice, and 528, once.

The method of inoculation employed was as follows: The vaccine, which appeared as a turbid fluid, was shaken before use and injected subcutaneously by means of a Pravaz syringe. The skin was first thoroughly washed with alcohol and ether. The vaccine was mostly introduced under the skin of the abdomen or the back, these injections usually causing little pain. Sometimes the injections were made into the cellular tissue of the shoulder or buttocks, but these places were not deemed convenient, as considerable pain resulted, impeding the free movements of the foot and of the arm. At first, when the dosage of the vaccine had not as yet been investigated, half a syringeful was inserted, but as an acute reaction generally ensued with children, it was considered essential to find a more exact dose in accordance with the age and the individuality of every child. I established the following dosage: children up to 5 years of age, when in good health and well nourished, were given as many divisions of the syringe as they were years old; children at the ages of from 5 to 10, when in good health and well nourished, received the same dosage; if the child was undernourished the dosage was somewhat smaller; for instance, a child of 8 was given six divisions of the syringe; a child of 7, five, and so on. Children over ten and adults received ten divisions. The reaction of the organism observed after the first vaccination determined the standard dosage to be followed in the subsequent injections. If the reaction was intense, the dose either remained the same or was diminished at the second vaccination; if the reaction, on the other hand, was weak, the dosage of the vaccine was increased by one and one half (e. g., six divisions to a child of 4); with the third vaccination, when the two first did not produce a very strong reaction, an amount double the first vaccination was used. Children under 1 year were not vaccinated at all, as they are generally not much subject to scarlet fever. I never introduced a dose exceeding 1½ syringefuls to adults (1.5 cc.).

The clinical picture of the disease after vaccination in average cases is generally as follows: On the evening following the injection the child becomes capricious and drowsy and goes to bed, with a temperature of 37 C. (98.6 F.) and fractions or 38 C. (100.4 F.) and sometimes even 38.5 C. (101.3 F.). The locus of injection swells, becomes painful to the touch and to movement; round it appears a small grained ellipsoid redness, eccentric toward the locus of injection, the long axis of this ellipse diverging from the spot of insertion along the lymphatic vessels toward the corresponding lymphatic glands. At the same time there is sometimes observed a redness in the direction of the lymphatic vessel of this part of the body, assuming the appearance of lymphangiotic red stripes. The nearest glands become swollen and painful to touch. With injections into the abdomen lower than the umbilicus there is sometimes a swelling of the inguinal glands, and the red stripes extend down to the groin; with an injection into an area lying higher than the umbilicus, i. e., under the shoulder bone, there appears a swelling of the arm-pit glands and the red stripes are directed toward the latter. In some cases, however, the red stripes could be seen only in the course of a very close examination along the lymphatic vessels. The redness along the locus, as already mentioned, looks like minute spots of scarlet fever eruption; in cases of strong reaction, on a general background of scarlet fever redness, there extend patches of hemorrhagic eruption. In the vast majority of cases the postvaccinal sickness is confined to these symptoms, which disappear in one or two days; only the swelling of lymphatic glands remains for three or four days more. Sometimes the reaction of the organism to the vaccine is insignificant; the temperature does not rise, or rises only from two to three decimals; the subjective status remains satisfactory; no redness and swelling round the area of injection are present and only a certain painfulness to touch can be observed.

However, in cases of strong reaction, the postvaccinal sickness resembles a grave infectious disease. The child becomes sleepy and is sometimes delirious; often the sleepiness is replaced by excitement; the child jumps up from bed, and talks in delirium. The temperature rises to 38.5 C. (101.3 F.), 39 C. (102.2 F.) and even 39.8 C. (103.6 F.). The eruption in typical dots appears not only round the area of injection but over the whole body, becoming especially marked in areas where two epidermic surfaces are in contact; viz., the neck, the groins or under the shoulders. Often, on a general background of scarlet fever eruption, there can be seen millet-like, minute bladders. Inspection of the mouth cavity and the pharynx reveals a startling increase in size and a redness of the papillae of the tongue in its forward third; the tongue is also frequently entirely red as it is with regular scarlet fever. On the walls of the pharynx, on the soft palate, tonsils and back wall of the throat there appears a redness, often composed of thickly set red spots and resembling a slight scarlet fever angina, lacking, however, deposits. Nausea and vomiting are also frequent in cases with malignant reaction, and I had one case of diarrhea. In some cases albumins (without tube casts) make their appearance but disappear within twenty-four hours. In one case a girl, aged 15, admitted on account of chronic nephritis, was vaccinated; after injection the temperature rose to 39.5 C. (103.1 F.); there was vomiting, abundant eruption, and blood in the urine; the albumin increased from 1 to 5 per thousand, and the blood disappeared only after five days.

In twenty-six cases after strong reaction desquamation of the upper epidermis could be observed, mainly localized in the neck, chest, soles of the feet and palms.

1. Gabritchevski: Ueber Streptokokkenvaccine und deren Verwendung bei der Drüse der Pferde und dem Scharlach des Menschen, Centralbl. f. Bakteriol., 1906; Streptococcus Vaccine with Scarlet Fever, Russk. Vrach, 1905; The Scarlet Fever Vaccine and the Problem of Specificity of the Scarlet Fever Streptococcus, ibid., 1905.

The reaction was always weaker after the second and third vaccination. There was usually no reaction at all after the third vaccination. In only nine cases after the second vaccination, and in three after the third did the temperature rise to 38.5 C. (101.3 F.), being accompanied by a thoroughly spread, though less marked, scarlatina-like eruption. But with a malignant reaction after inoculation, attended by high temperature, general eruption, angina, and scarlet tongue, the picture of postvaccinal sickness was so similar to that of genuine scarlet fever that had one not been aware of the actual vaccination, the diagnosis of scarlet fever would doubtless have been established; desquamation, which was also sometimes observed, gave still more support for regarding the postvaccinal sickness and genuine scarlet fever as closely similar. I observed the following complications of the postvaccinal sickness: two children developed an acute polyarthritis on the second week after a single vaccination, the illness, however, soon passing away.

Another child, the second week after a single vaccination, gave evidence of acute nephritis (dropsy, albumin and tube casts) with subsequent recovery. Unfortunately, it was impossible in this case to determine exactly what the real reason for nephritis had been, and whether there had not been genuine scarlet fever, the child having been in the country where his parents were unable to procure the necessary information.

An insignificant or weak reaction (no local eruption around the locus and no rise in temperature) was observed with the first vaccination in forty-four cases, or 13.2 per cent; with the second in 25.9 per cent of cases, and with the third in 55 per cent. Thus, with the first vaccination we obtained 17 per cent strong reaction, 13.2 per cent medium, and 69.8 per cent weak; with the second, 7.3 per cent strong reaction, 25.9 per cent weak, and 66.8 per cent medium; with the third, 2 per cent strong, 55 per cent weak, and 43 per cent medium.

Desquamation was observed in 34 per cent of the total number of cases. Subsequent diseases developed in 1.5 per cent of all cases.

It is especially noteworthy that children who had indubitably undergone scarlet fever did not react at all toward inoculation; there were nine such cases.

Children whose parents had had scarlet fever showed a weak reaction, while children, both or only one of whose parents had never been subject to scarlet fever, gave a medium or strong reaction. This feature can be regarded as one more proof to the effect that the streptococcus is actually the scarlet fever germ, toward which an hereditary immunity is worked out after the disease has once been present.

Of the 767 patients vaccinated, only eight fell ill, all in the group which had had just one vaccination, thus forming 1.05 per cent of all vaccinated cases and 1.5 per cent of singly vaccinated children; as to those children who had been vaccinated two or three times, none of them caught the disease, though the larger number (578 of 767) were from infected communities, and some of the vaccinated children entered into direct contact with the diseased.

REPORT OF CASES

CASE 1.—D., a girl, entered the hospital for treatment of extensive scalds, remained in the ward three months, and during that time was vaccinated twice. When she was taken home, there were two severe cases of scarlet fever in her family (her brother and sister). She slept on the same bed and was in close contact with the patients. The boy died, and the girl suffered from malignant scarlatina nephritis, but the vaccinated patient remained in good health.

CASE 2.—In this family there were two boys, one of whom had been vaccinated in school three times and the other had not; both boys used to call on a friend suffering from scarlet fever. The nonvaccinated child fell ill, but the boy who had been vaccinated remained in good health.

CASES 3 to 10.—These are examples of the eight postvaccinal cases of scarlet fever. A girl, aged 8, caught scarlet fever one month after vaccination. The disease was of medium severity and was accompanied by necrotic quinsy and purulent otitis. A boy from the same family, who had been vaccinated once, fell ill of scarlet fever in a medium severe form, from which he recovered; nephritis developed later, and the child died in an attack of uremia. As to the remaining six cases, one boy, after a single vaccination, had light scarlet fever, and subsequent nephritis with ultimate recovery. The other five children all had a light form of scarlet fever, while their noninoculated brothers and sisters had heavy cases.

CASE 11.—O. K., a girl, aged 6, vaccinated, May 28, had a malignant reaction with general eruption, angina, vomiting, delirium, and a temperature of 38.4 C. (101.1 F.). There was no second inoculation.

September 10, her little sister, aged 2, became ill, followed simultaneously by the patient under observation and her other little sister, aged 8. All were transported to the hospital. The 2 year old girl showed symptoms of a very heavy if not hopeless case (group III of Moser's classification), unconsciousness, unequally shared eruption, necrotic angina and a temperature of 40.8 C. (105.4 F.). The girl died on the fifth day of the illness. On the other hand, with the vaccinated patient, O. K., the temperature never rose higher than 38 C. (100.4 F.), the eruption was equally propagated, angina was insignificant, and there was subsequent recovery. Judging by the malignant reaction toward vaccination, we may assume that the patient was greatly receptive toward infection, but the receptivity was weakened on account of vaccination, while the resistance of the organism toward the virus had increased. Falling ill under the same conditions as her sisters, and contaminated by an infective agent of the same virulence, the patient endured a much lighter form of the disease than did her sisters.

COMMENT

Though a single inoculation does not afford complete immunity toward the scarlet fever virus, as the cases of illness exclusively from the single-vaccinated group show, there exist indications to the effect that even a single vaccination produces a certain degree of immunity, and sometimes enables the health officer to reduce the severity of an epidemic. Thus, at the outbreak of the first cases of scarlet fever in three villages, Griasi, Salkovo and Natashino, in the Zvenigorod health district, practically all children were vaccinated: forty-four in Griasi, twenty-four in Salkovo and thirty-six in Natashino. None of those vaccinated fell ill, while two nonvaccinated adults caught scarlet fever in Salkovo, and one boy, shortly arrived from Moscow, and one adult had the same fate in Griasi. One could assume that the infection was still present in the village: the vaccinated children obtained a certain immunity and remained healthy, while adults, as a whole very rarely subject to scarlet fever, fell victims to the disease. None of the vaccinated children fell ill in Natashino; but three caught a virulent form of the disease one week before vaccination, and one child died.

INFLUENCE OF INOCULATION

The scarlet fever epidemic in the Zvenigorod health district began at the end of the summer of 1905 and showed an immediate tendency to propagate.

The epidemic was a rather heavy one, with about 20 per cent of deaths and a considerable amount of

consecutive, mainly hemorrhagic, nephritis. At the end of 1905 and the beginning of 1906, four villages[2] in which there had been no previous vaccination had an average percentage of sixteen children aged from 1 to 14 ill. If the ratio of postvaccinal illness cases with children (8) to the total amount of children vaccinated (in villages with cases of scarlet fever, 578) is taken, there is a percentage of illness of 1.4. This was with single vaccination. As to individual villages, we get the following data: In Funtikovo there was an outbreak of several heavy cases; forty-five children were vaccinated; twelve twice and thirty-three once. The total number of children in the village was sixty-two. Hence, seventeen were not vaccinated. Of these seventeen, two fell ill, or 65 per cent. Scarlet fever did not occur among the vaccinated. These facts give indubitable proof of inoculation, enabling us to cut down an epidemic. The very peasants were so struck by this that, when scarlet fever appeared in the vicinity, they began of their own accord to ask for vaccination to be administered to their children, in order to put a stop to the spread of the disease.

Regarding the conditions under which a child may be vaccinated, the following facts should be taken into account: The patient should not be vaccinated in the febrile stage, because even theoretically an organism, when fighting with a certain virus, has more difficulty in producing immunizing antibodies toward any other infection (scarlet fever in the present case) and also as the enforced labor of the organs caused by the insertion of vaccine cannot be done with impunity for the whole organism. The second condition for vaccination is normal work on the part of the kidneys. Clinical experience shows without the slightest doubt that the kidneys are especially attacked by the scarlet fever virus (consecutive nephritis). We may presume that the streptococcus vaccine also has an irritant action in this respect, as in the foregoing case of a girl suffering from chronic nephritis with whom the insertion of 0.6 cc. of vaccine caused an aggravation of her malady. Dr. Dreiling[3] cites two cases; one in which an enormous dose of 5 cc. of vaccine was given to a boy, aged 5, after which symptoms of nephritis appeared in twenty-three days; and the other, a case of hemorrhagic nephritis which developed two weeks after the injection of 0.8 cc. of vaccine. The first two cases prove only that under abnormal conditions such as kidney disease or an exaggerated dose of vaccine, streptococcus vaccine has a detrimental influence on the kidney epithelium; but this circumstance, coupled with a kind of specific action of scarlatina virus on the kidneys, tends to make one especially careful with regard to the state of kidneys at vaccination.

Whether it is advisable to vaccinate in families in which cases of scarlet fever are actually present, the general practitioner must first take into account the temperature of the person to be vaccinated, as a raised temperature indicates a disease already begun; in such a case, vaccination would be useless. One should also allow for the possibility of incubation proceeding under normal temperature. It is therefore advisable to insert simultaneously with the vaccine a small dose (from 25 to 50 cc.) of Moser's[4] serum, giving a rapid but brief immunity toward the disease, which might develop from the virus eventually communicated to the child; subsequently, immunity ensues on account of the working out of immunizing substances due to the vaccine inserted. Should the patient, on the other hand, be isolated from his family, the vaccine alone may be injected but only after the incubation period has elapsed (from five to seven days).

CONCLUSIONS

1. The postvaccinal sickness is similar to genuine scarlet fever.
2. The inoculation of vaccine is harmless.
3. Immunity after vaccination is acquired only after repeated inoculation (two or three injections).
4. Vaccination decreases the number of scarlet fever cases and is helpful in cutting down epidemics in settlements.
5. Especial attention is to be paid to temperature and the state of the kidneys at inoculation.

2. Chaszi, Tatarka, Ivanino and Sharapovo.
3. Dreiling: Report on the Contagious Maladies of Moscow Government, 1906.
4. Moser: Die Serumbehandlung bei Scharlach, Wien. med. Wchnschr. 1903.

TYPHOID OSTEITIS AND PERIOSTITIS*

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The frequency of typhoid bone infection is given by fifteen authors as occurring 164 times in 18,840 cases (0.87 per cent of all cases having metastatic infections in the bone). In 700 cases of osteomyelitis, only three were due to typhoid (0.43 per cent of all osteomyelitis). These statistics are rather uncertain, as in many cases the bacteriology is not determined. The occurrence of typhoid bone infection is probably much more frequent than the statistics would indicate, as a great number of the typhoid infections do not suppurate and are never opened. Frequent recurrence of pain, swelling and tenderness of a typhoid bone may result in an ultimate complete cure. Typhoid bone infection is much more frequent in males than in females, because a larger percentage of males have typhoid fever, and a greater frequency of trauma to the osseous system from occupation. It has been known to appear as early as the thirteenth day or as late as forty-five years after the onset of the typhoid infection. It is thought that the patients developing bone infection years after the initial infection are typhoid carriers, usually in the gallbladder, the genito-urinary or gastro-intestinal tract. In this way the bone infection is only a coincidence, as a typhoid bacteremia must frequently occur.

LOCATION

Almost every bone of the skeleton has been reported to have been affected with typhoid; the most frequent, given in the order of their frequency, being ribs, tibia, spine, femur, humerus, ulna, foot and clavicle. These are the bones most exposed to trauma.

The periosteum is the part most frequently affected primarily, though in many cases diagnosed as periostitis there is soon an osteitis showing "collar button" absorption or excavation. It is usually seen in the diaphysis farther away from the epiphyseal line than the metastatic lesions, caused by the staphylococcic infection from boils, and the upper respiratory infection in the adolescent patient. The primary lesion appears first

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in the periosteum followed by a small cortical destruction. This may progress to a generalized periostitis of the bone affected, with few or many small "collar button" abscesses.

PATHOLOGIC ANATOMY

The infection may involve the medulla, periosteum, osseous tissue, or cartilage. When the periosteum is involved, it is stripped from the bone, first forming a fluid beneath, with little involvement of the bone. The process may be so slow that the osteogenic power of the deeper layers of the periosteum may cause an exostosis. It may require months for the process to develop.

Pure cultures of typhoid cause very little leukocytic response but produce a slow inflammatory destruction of the tissue, of the cold abscess variety. When sought for, a pure typhoid culture can be easily demonstrated, if present. Even in old bone sinus cases, a pure culture of typhoid is frequently obtained.

The constitutional symptoms are usually not frankly manifested, frequently suggesting the bone pains of secondary syphilis, with frequent recurrences to be followed later with necrosis, and small bone abscess or abscesses.

ROENTGENOLOGIC CHANGES IN THE LONG BONES

The simplest process in the long bones is a localized periostitis with a small abscess, which may be multiple, usually situated in the cortex, just adjacent to the periosteum; it is rarely larger than 1 cm. in diameter, is circular or oblong in appearance, and it casts a shadow of lesser density than the surrounding bone. The limited area may suggest the etiologic factor, as may the slight immediate bone reaction.

When the involvement is limited to the periosteum, the cortex may show extensive involvement and may spread for several centimeters. The limit of periosteal involvement is usually much less than is present in the syphilitic periostitis, with its marked osteosclerosis. The bone destruction is much less than in the metastatic, staphylococcic bone infection so frequently seen in the young and adolescent patient.

DIFFERENTIAL DIAGNOSIS

In typhoid, the destruction is usually small; there is little immediate bone reaction, and the lesions are rarely larger than 1 cm. in diameter.

In Brodie's abscess, the immediate bone reaction is increased and the lesion is larger.

In acute osteomyelitis, the destruction is great, with marked bone reaction, and usually the entire diaphysis is involved.

In typhoid periostitis, the involvement is not so extensive as in syphilitic periostitis. There is much less immediate bone reaction, with very little osteosclerosis in comparison to that seen in syphilitic periostitis. Syphilitic periostitis can be easily recognized on the roentgenogram, and is accompanied by a positive blood Wassermann reaction.

TYPHOID SPINE

In eighty-eight cases of spine lesions recorded, the locations were as follows: Cervical, one; dorsal, eight; dorsolumbar, ten; lumbar, fifty-nine; lumbosacral, six; sacral, four. The dorsolumbar area is most frequently involved because of its frequent trauma, and the greater motion and pressure due to the sitting position during convalescence.

ROENTGEN-RAY CHANGES

The roentgen-ray changes seen are destructive changes in the bodies of the vertebrae with absorption in the intervertebral disks, which are thinner and "blurred." Later, new bone deposits are seen around the vertebral bodies, with exostosis laterally to the spine, and with bony deposits in the vertebral ligaments. Frequently, clasplike bony projections are seen laterally connecting the bodies of the vertebrae. Bone deposits in the lateral ligaments may show when the first symptoms are experienced by the patient.

From a careful review of the cases reported, the first changes seen are thought to be in the intervertebral disks, followed with an involvement of the body of the vertebrae and the lateral margins with exostosis, and bony deposits in the adjacent lateral ligaments. In the case reported, there was very definite "blurring" of the vertebral bodies involved, with definite narrowing of the joint space, accompanied by bony deposits in the adjacent lateral margins of the vertebral bodies and lateral ligaments. The anterior margins of the vertebral bodies showed the presence of bony deposits, such as were seen at the lateral margins, although not so extensive. In the anteroposterior film, there was a general mottled appearance over the lateral ligament areas, extending to the external margins of the shadow of the psoas muscle. Apparently this is new bone, as dense as the vertebral bodies, uniting the vertebral bodies in a clasplike bone formation.

There is usually a history of mild trauma, followed by excruciating pain on either passive or active movement, the patient begging not to be disturbed. A history of typhoid can usually be obtained.

DIFFERENTIAL DIAGNOSIS OF TYPHOID SPINE

Roentgenologic differentiation in typhoid spine is based on the dense bony deposits in the lateral ligaments, with evidence of narrowing of the intervertebral space. The adjacent soft tissues show an increase in density, giving a "blurred" or cloudy appearance surrounding the involved vertebral bodies.

Malignant metastasis in the spine usually affects one or more entire vertebral bodies with almost complete decalcification, the body retaining its normal shape. No bony deposits are seen around the body, or in the lateral ligaments. It is a destructive lesion.

In tuberculosis, the primary articular destruction accompanied by bone destruction, and the collapse of one or more bodies with the presence of a "bosse" are quite well known.

In hypertrophic arthritis, many vertebrae are involved, with lipping and filling of the articular spaces, usually seen in elderly patients. This is rarely seen in the early stages.

In spondylitis deformans, other joints are involved. The patients are past middle life and quite often present a kyphosis which may involve the entire spine.

A Charcot's spine shows both bone destruction and bone production with a large amount of detritis, as seen in Charcot's joint, elsewhere in the body.

In lumbago and neurasthenia, no roentgen-ray changes are seen.

REPORT OF CASES

CASE 1.—*A small periosteal lesion of the ulna.* A girl, aged 12 years, suffered a mild attack of typhoid with a positive Widal reaction and a positive blood culture of typhoid bacillus. In the early convalescence, the tenth week after the typhoid onset, the patient complained of pain in the right ulna. On examination, there was a local tenderness, definite

evidence of elevation of the periosteum on careful palpation, and the appearance of a very small cortical enlargement on close inspection.

On roentgen-ray examination, there was very definite destruction of a localized area of periosteum, with an area of lessened density quite characteristic of a very small bone abscess. There was no immediate bone reaction.

Operation revealed a small amount of serum and pus, with a small area of periosteal destruction. The bone was curetted, and a cure recorded with primary healing. No culture was made from the pus obtained at operation.

As only thirty of the 104 cases of typhoid spine recorded in the literature up to 1918 were accompanied with roentgenograms, it appears to us to be instructive to record our case, which shows definite roentgen-ray changes. In the roentgen-ray literature available, no cases were recorded with roentgenograms, and only two abstracts on the subject were found.

CASE 2.—*Typhoid spine.* A man, aged 50, seen in July, 1925, had a mild attack of typhoid. About September 15, while walking in his yard, he tripped on a stick and fell, catching himself on his hands and knees. He had to be assisted in arising. He experienced excruciating pain in the dorsolumbar area, and during the next three weeks was confined to his bed. Any movement, either passive or active, caused excruciating pain in the lumbodorsal region, with powerful and painful contraction of the muscles of the spine.

When first seen, Oct. 6, 1925, any attempt at motion was followed with severe pain, the patient begging not to be moved. He had to be lifted and turned in a sheet for roentgen-ray examination.

Films of the lower dorsal and lumbar spine in the anteroposterior and lateral positions showed a hazy appearance over the bodies of the first and second lumbar vertebrae, with definite narrowing of the joint spaces between these two vertebrae.

In the anteroposterior view, dense bony shadows were present, extending outward from the adjacent lateral margins of these two vertebrae, with clasplike formation, which appeared to unite these two vertebral bodies. The outgrowths were of as great or greater density than the adjacent vertebral bodies, and appeared to be true bony outgrowths. There was very definite evidence of exostosis, and an attempt at bony union at the anterior margins of the first and second lumbar bodies was seen in the lateral view.

A body plaster-of-paris dressing resulted in complete relief of pain with a clinical cure in three months, accompanied by a great gain in weight. No vaccines or other medicinal agents were given.

CASE 3.—*Multiple bone infection in a patient having typhoid.* A man, aged 43, married, with five children, and with no history of miscarriages in the family, suffered a severe attack of typhoid at the age of 20. In the third month after the onset, he suffered a relapse.

During his second convalescence, an abscess developed in the left inguinal region. After several days it pointed near the rectum, and when opened, a large quantity of pus was obtained. Persistent, multiple sinuses resulted. No roentgen-ray examination was made (twenty-three years ago). Several weeks later, at the operation, the sinus was found to terminate in the left pubic bone. Since this time, the sinuses have continued to open occasionally, and to drain for a few weeks, then heal and remain healed for several months. The sinuses are present to date.

Eight years after the typhoid infection, the left tibia and fibula became involved. After four bone curettements, a cure was obtained. Many scars are present but no sinuses persist. Roentgenologically, these bones appear normal at the present time.

Ten years after the typhoid infection, an infection appeared in the right radius. Several operations have not resulted in a cure. Many scars on the forearm on the radial side are present.

Recent roentgen-ray examination reveals the presence of an extensive periostitis and osteitis of the right radius, with less osteosclerosis than is seen in syphilitic periostitis, with the presence of localized bone abscesses. Two operations, the last one three years ago, have not resulted in a cure. A sinus persists. There are several scars from healed sinuses. Many small abscesses are seen in the skin in the forearm. The cultures from the sinuses in the radius at present are *Staphylococcus aureus.* A culture from the bone abscesses has not been obtained.

In this case blood culture at present gives a negative typhoid culture, also a negative Widal reaction. Urinary and feces examinations are negative for typhoid growth. The blood Wassermann reaction is negative. Cultures from sinuses and from the small skin infections on the forearm show a pure culture of *Staphylococcus aureus.* No cultures have been obtained from the bone sinuses.

In the fourteenth annual survey of the U. S. Census Bureau, 1925 was considered a typhoid year, there being a definite increase in typhoid disease, especially in the South and Southeast. In this report, the state of Ohio for August, 1925, shows an increase of 35 per cent over August, 1924. May we not be on the lookout for an increase in typhoid bone infection? We, as roentgenologists, should be prepared to recognize its presence. We believe that by a careful study of the roentgen-ray changes, typhoid bone infection can frequently be diagnosed.

SUMMARY

1. Typhoid bone infection is probably much more frequent than has been recorded.

2. It is not seen frequently at present, as there has been comparatively little typhoid in the last ten years.

3. With a careful roentgen-ray study, it can be recognized in the long bones by its location in the diaphysis, usually some distance from the epiphysis, by the small area or areas of involvement with so little adjacent bone reaction.

4. It should be differentiated from Brodie's abscess by its location, and periosteal involvement with little immediate bone reaction.

5. There is a lesser area of periosteal involvement than is seen in syphilitic periostitis, with comparatively less osteosclerosis.

6. Typhoid spine gives very constant roentgen-ray changes that can and should be recognized.

7. The etiologic factor can at least be suggested by its roentgenographic appearance, and by careful attention to the bony changes.

8. In typhoid spine and the early small lesions of the long bones, the changes are constant and should be recognized.

9. In the extensive lesions of the long bones accompanied by mixed infection, usually staphylococcus, its differentiation is easy and its small size may cause us to give a suggestion of the etiologic factor.

ABSTRACT OF DISCUSSION

DR. E. S. BLAINE, Chicago: Dr. Baetjer's cardinal points in roentgen-ray analysis are the mainstay in arriving at correct conclusions in bone cases. Then, if the laboratory changes prove us wrong, we shall have learned something from every bone or joint case we encounter that does not give roentgen-ray shadows "according to Hoyle." Many of the osseous hypertrophies that we find so often in the lumbar vertebrae are localized, and we find these changes sometimes in surprisingly young persons (the early twenties) which do not fit in with the accepted idea of focal infection changes. I recall very well the case of a switchman weighing about 240 pounds (110 Kg.) who had fallen from a freight car and hurt his back. The roentgenogram was reported as showing a fracture of the lumbar spine. It had been taken shortly after the injury, and the man's lawyer made out a case of

a spine fracture with a large amount of callus and was awarded damages. I later examined these films, and saw typical roentgen-ray shadows of osseous hypertrophies commonly found to be due to focal infections. Dr. Keirn's presentation makes me a little more certain now than I was then that this man, who got $30,000 damages for a fracture of the spine, was not seriously injured, but was the lucky recipient of a large amount of money for the results of a low grade infection with which the railroad had nothing to do.

DR. H. W. MEYERDING, Rochester, Minn.: An important point to bear in mind is the fact that in typhoid osteomyelitis we have a history of typhoid available in most cases. I have seen typhoid osteomyelitis entirely missed in the roentgenogram in spite of the fact that there was a history of localized pain, and examination of the roentgenogram revealed definite bony change. On exploration, however, and bacteriologic examination, typhoid osteomyelitis was demonstrated. In these conditions, first, we must have some knowledge of the case to interpret the roentgenogram, and next, the surgical exploration and bacteriologic examination should be carried out at the same time, for it is only through careful study that we shall ultimately arrive at definite scientific conclusions regarding what we see in the plates.

DR. J. W. CATHCART, El Paso, Texas: I wish to stress the fact that in many instances the roentgenograms are negative. I feel that the most good I have done in osteomyelitis cases has been with those patients in whom the evidence of the negative roentgenogram has induced the surgeon to open up the medullary canal. If the roentgenogram is negative before the time arrived, we can save the bone. If it is positive, it is too late; so as radiologists we should lend our moral support to the surgeon in getting him to go in early.

THE INFLUENCE OF FOCAL INFECTION AND THE PATHOLOGY OF ARTHRITIS

RESULTS OF EXPERIMENTS: SECOND PAPER *

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It is generally accepted that focal and other infections are the cause of many cases of arthritis. It is the belief of some that all cases are due to this agency alone, but dispassionate students of the disease are almost unanimous in the belief that other factors also play a rôle, and that focal infection is often only the "match to the priming," even when operative. There is also strong evidence that focal infection may arise as the result, as well as the cause, of the arthritic syndrome. In any event, the manner in which bacteriologic infection exercises its influence has not been made clear. There are cases of arthritis undoubtedly characterized by bacteria in situ and even by the formation of free pus; but the evidence that all cases of arthritis are caused and perpetuated by bacteria in the joint tissues is far from convincing. The inclination to ascribe arthritis to such a simple mechanism is obviously tempting, but even if accepted there yet remains to be explained how the actual pathologic changes of arthritis arise.

It cannot be assumed that bacteria per se remove bone and produce overgrowth of bone without the intermediation of those chemical reactions involved in the normal physiologic processes of bone; and in their classic monograph on the morphology of arthritis, Nichols and Richardson lay emphasis on the metabolic influences at work. The occurrence of Charcot's joints alone necessitates consideration of a mechanism other than one purely bacterial; and this is also true of those instances of arthritis in which removal of a remote focus is followed by almost immediate recovery. In such cases there is hardly time or opportunity for an infected joint to become sterile. Other considerations of the kind have been advanced elsewhere.[1]

It appears necessary to assume that some underlying disturbance of the physiologic function, probably of wide expression throughout the economy, is set in motion, or perpetuated, by focal infections or the other agents that may induce arthritis.

The justifiable and sound conception that focal infection is a cause of arthritis has properly received wide acceptance. Emphasis on the bacteriologic influences, however, has incidentally brought about, in some quarters, an attitude of finality toward the actual pathologic processes concerned and, with this, a failure to recognize that there must be some method or mechanism through which infection acts. Attempts to analyze this mechanism have been sometimes interpreted as evidence of disagreement with the doctrine of focal infection, whereas in fact such effort is in the opposite direction.

This preliminary statement is believed necessary to indicate the purposes of the present studies and to disclaim any attempt to negative or minimize the accepted important rôle of infectious processes in arthritis. Elucidation of the nature of the influence exerted by infectious foci would probably explain a host of disease conditions and be fraught with important clinical consequences.

In a previous communication, the suggestion has been advanced by one of us[2] that part of the pathologic changes of arthritis and the rheumatoid syndrome depend on a disturbance in the blood supply of the parts concerned, particularly in the finer capillaries. In a subsequent communication, evidence has been adduced by Pemberton, Cajori and Crouter[3] substantiating this suggestion. This evidence was based on the following considerations: the delay in the rate at which glucose leaves the blood after ingestion by the arthritic patient; the blood gases in arthritis; absorption from the intestinal tract in arthritis, and the influence of the circulation on the rate of removal from the blood of ingested sugar.

In order to make clear the relevance of the present experiments it will be necessary to present a brief summary of the foregoing considerations.

1. It has been shown[1] that 60 per cent of all arthritic patients present a delay in the rate at which sugar leaves the blood after ingestion by mouth, and that this delay grows less or disappears after recovery from arthritis, whatever the treatment employed. It does so most abruptly, however, after the removal of causative infection. As a corollary to this, the occurrence of an inflammatory process, such as sinusitis, may induce a delay in the rate of removal of glucose in a previously healthy subject with a normal sugar disposing mechanism.

2. Studies of the blood gases[4] during the conduction of a test revealing a delayed removal of sugar from the blood showed a rise in the percentage oxygen saturation of that blood in a large majority of cases. Inability to relate this "accumulation" of oxygen to chemical processes implies that

* From the laboratory of Clinical Chemistry, Presbyterian Hospital. The work here reported is part of a study on chronic arthritis in collaboration with Dr. Robert B. Osgood of Boston. The expenses of the investigation were defrayed by contributions from several sources, including a number of patients.

1. Pemberton, Ralph: Etiology and Pathology of Arthritis, J. A. M. A. 87: 1253 (Oct. 16) 1926.
2. Pemberton, Ralph: Am. J. M. Sc. 166: 833 (Dec.) 1923.
3. Pemberton, Ralph; Cajori, F. A., and Crouter, C. Y.: Influence of Focal Infection and Pathology of Arthritis, J. A. M. A. 85: 1793-1798 (Dec. 5) 1925.
4. Pemberton, Ralph; Hendrix, B. M., and Crouter, Caroline Y: J. Metab. Research, September, 1922.

the blood fails to reach all tissues of the body, or that the circulation is accelerated. In either event, the result would be to leave some of the normal components of the blood unutilized.

3. In view of the suggestion of an increased rate of circulation in arthritis, the hypothesis was advanced that absorption from the gastro-intestinal tract might in consequence be unduly rapid. This might account for the delayed sugar removal and the value of a low diet in a certain proportion of arthritic cases. This hypothesis was therefore tested[8] by feeding urea and potassium iodide coincidentally with the sugar. Omitting details, the results gave no support to the theory of an increased rate of circulation and absorption, and left as one alternative the theory that the blood inadequately reached some tissues.

4. This hypothesis was therefore tested[9] by interfering, through posture, with the blood flow in the limbs of arthritic and normal persons, and then examining the sugar-removing mechanism. The results showed that in half of the arthritic cases studied it was possible to induce a delay in the removal of sugar from the blood after ingestion by arthritic subjects presenting otherwise a normal rate of removal. In view of ingestion, in essentially the same proportion of cases; namely, 50 per cent. It is of interest to note that so far this delayed removal has not been induced in a supposedly normal person.

In a previous publication,[1] the incidence of a spontaneously faulty sugar-removing mechanism in arthritis, when uninfluenced by experimental posture, has been given as 60 per cent. It is evident, however, from the statements just made that a delayed removal of sugar is potentially present in a larger proportion of arthritic patients than 60 per cent. Among the remainder of arthritic patients (40 per cent) who give a normal sugar-removing mechanism, many others will also show a delayed removal if the blood flow to the limbs is interfered with. Since normal persons apparently do not react in this way, it implies that there already exists in the arthritic patient, showing a normal rate of removal, a partial interruption of some vascular channels, such that further interference with the blood flow is sufficient to induce a delayed rate of sugar removal

Influence of Vasodilator Drugs on the Glucose-Disposing Mechanism

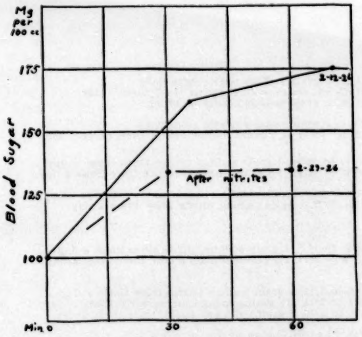
	Before Nitrites			After Nitrites			
Subject	Date	Time, Minutes	Blood Sugar, Mg. per 100 Cc.	Date	Time, Minutes	Blood Sugar, Mg. per 100 Cc.	Nitrite Dosage
1	11/20/25	0	103	11/23/25	0	...	11/21, 1 grain sodium nitrite twice daily
		30	173		35	146	11/22, 1½ grains sodium nitrite three times a day
		60	188		65	154	11/23, 1 grain sodium nitrite on rising
2	12/ 7/25	0	...	12/10/25	0	...	12/ 7, 1 grain sodium nitrite twice daily
		30	149		30	159	12/ 8, to 12/10, 1 grain sodium nitrite three times a day
		65	198		60	188	
				12/18/25	0	...	12/11 to 12/16, 1 grain sodium nitrite three times a day
					30	201	12/16 to 12/18, 1½ grains sodium nitrite three times a day
					60	229	
3	12/ 9/25	0	...	12/28/25	0	...	? to 12/27, 1 grain sodium nitrite three times a day
		30	146		35	122	
		60	181		65	159	
4	12/29/25	0	106	1/11/26	0	...	12/31 to 1/ 5, 1 grain sodium nitrite three times a day
		30	153		35	185	1/ 5 to 1/11, 1½ grains sodium nitrite three times a day
		60	177		63	152	
5	1/ 8/26	0	108	1/16/26	0	...	1/ 9 to 1/11, 1 grain sodium nitrite three times a day
		33	169		32	175	1/11 to 1/14, 1½ grains sodium nitrite three times a day
		62	225		62	199	1/14 to 1/16, 2 grains sodium nitrite three times a day
6	2/12/26	0	100	2/27/26	0	...	1/16, 2 grains sodium nitrite on rising
		35	162		30	134	2/15 to 2/25, ½ grain erythroltetranitrate three times a day
		70	175		60	135	2/25 to 2/27, ½ grain erythroltetranitrate four times a day
7	3/15/26	0	101	3/27/26	0	...	3/16 to 3/22, ¼ grain erythroltetranitrate twice daily
		35	197		30	178	3/22 to 3/25, ½ grain erythroltetronitrate twice daily
		75	159		75	178	3/25 to 3/27, ⅜ grain erythroltetranitrate twice daily
				5/ 7/26	0	...	4/24 to 4/27, ½ grain erythroltetranitrate three times a day
					35	171	4/27 to 5/ 7, ½ grain erythroltetranitrate twice daily
					75	174	
8	3/23/26	0	103	4/ 6/26	0	...	3/26 to 3/30, ½ grain erythroltetranitrate twice daily
		50	191		30	160	3/30 to 4/ 3, ½ grain erythroltetranitrate three times a day
		75	180		60	135	4/ 3 to 4/ 5, ½ grain erythroltetranitrate twice daily
9	3/26/26	0	100	5/ 5/26	0	...	4/ 6 to 4/ 8, ¼ grain erythroltetranitrate twice daily
		35	140		30	181	4/ 8 to 4/12, ¼ grain erythroltetranitrate three times a day
		65	230		60	175	4/12 to 5/ 4, ½ grain erythroltetranitrate three times a day.
10	4/13/26	0	117	5/13/26	0	...	4/15 to 5/ 6, ¼ to ⅜ grain erythroltetranitrate three times a day
		30	202		30	207	5/ 6 to 5/13, ½ grain erythroltetranitrate three times a day
		60	202		60	216	

the close relationship between a delayed sugar removal, arthritis and focal infection, this is strong evidence that a disturbance of the circulation, probably in the nature of closed capillary areas, constitutes an important part of the pathologic basis of arthritis and the rheumatoid syndrome. If these observations are correlated with the well recognized benefits occurring in arthritis from measures that improve the circulation, the evidence becomes stronger.

Since publication of the foregoing, further data have been accumulated which strengthen the conclusions reached. A total of twenty-one arthritic and four normal persons has now been studied, with the result that this larger series shows the experimental induction of a delay in the removal of sugar from the blood, after after ingestion. This occurs in 50 per cent of arthritic patients showing a "normal" sugar-disposing mechanism. If, therefore, these figures are combined, the total proportion of arthritic persons showing an actual or potentially delayed rate of removal of sugar from the blood after ingestion is 80 per cent.

The clear-cut results cited above made it important, therefore, to ascertain whether any influence could be exercised on an already existing lowered sugar "tolerance" of nondiabetic nature, by opening up vascular channels. This is obviously the opposite of the line of experimentation just recorded, and if successful would afford proof of the correctness of the conclusions

reached. It was determined, therefore, to place a series of arthritic patients who had been ascertained to have a lowered rate of sugar removal under the influence of a vasodilator drug such as sodium nitrite, with the aim of determining before exhibition, and again following a period of exhibition, the rate at which sugar leaves the blood after ingestion by mouth. The period during which the patient was subjected to the influence of vasodilator drugs varied from three days to several weeks, but in every instance the determination of the delayed sugar removal was made immediately or shortly before the institution of treatment, and every effort was made to administer the drug in regular, and generally increasing, doses so that a definite physiologic influence might be obtained. This influence was so definitely achieved that, in some instances, it became necessary to withhold the drug or reduce the dosage pending the disappearance of such symptoms as vertigo. In some instances observations were also made on the blood pressure, although the latter was not always affected, as some of the cases studied presented a blood pressure already fairly low,



Influence of vasodilator drugs on the glucose-disposing mechanism of subject 6. Blood sugar was still rising at end of one and one-fourth hours in curve made before administration of nitrites.

and exhibition of the drug to the point of influence on it would have been unjustifiable. Administration of sodium nitrite in doses of from 1 to 2 grains (0.065 to 0.130 Gm.) from twice to three times daily and erythroltetranitrate in doses of from one-eighth to one-half grain (8 to 32 mg.) from twice to four times daily was carried out in ten cases of arthritis in which a delayed sugar removal had been ascertained to be present. On repeating the determination of the sugar curve after exhibition of vasodilator drugs it was found in 60 per cent of these cases that this lowered rate of sugar removal returned definitely toward normal. The administration of glucose and the determination of the blood sugar were carried out under the conditions and the methods previously described.[5]

The results obtained in these experiments are given in the accompanying table. The chart illustrates a typical case.

These experiments therefore present evidence that a delayed removal of blood sugar, of nondiabetic nature, can sometimes be restored toward or to normal by vasodilator drugs, which are known to open up vascular channels. In view of the parallellism between arthritis, focal infection and a "lowered sugar tolerance" of nondiabetic nature, this is additional evidence that at least part of the pathologic change of arthritis and the rheumatoid syndrome is referable to interference with the blood supply in the smaller vessels.

These experiments also emphasize again the distinction that must be observed between a lowered sugar tolerance as generally understood, in the diabetic sense, involving a failure of combustion, on the one hand; and, on the other hand, a "lowered sugar tolerance," better termed a delayed sugar removal, of nondiabetic nature dependent on changes in the blood supply, probably especially to the muscles. It is obvious that a change of this nature may induce an overflow of glucose from the blood into the urine, especially if the renal threshold is low. It also illustrates one way in which focal and other infection may serve to aggravate a condition of true diabetes, by placing out of commission, temporarily, part of the machinery involved in at least the early steps of carbohydrate metabolism.

If vasodilator drugs are capable of restoring toward normal part of the dynamic pathologic change that accompanies arthritis, it would appear conceivable that a favorable influence might also be exercised by them toward some clinical phenomena of the disease. Observations were accordingly undertaken on arthritic patients in various stages of the disease to whom vasodilator drugs, chiefly sodium nitrite and erythroltetranitrate, were administered. It seems justifiable to record that in twelve instances out of thirty-two cases, or 37 per cent, a favorable influence was observed on the arthritic or rheumatoid syndrome at selected periods of treatment. In some of these cases the nitrites were administered alone and, in others, in conjunction with various measures, but always under such circumstances as to make it possible to give some interpretation as to the effects of the drug. Some of these cases had been studied so long as to make it possible apparently to relate definitely to these drugs any favorable influence that followed their use.

It is not be understood that anything in the nature of a panacea is hereby suggested. Nothing further is implied than that a favorable influence has been observed in a limited number and proportion of cases. Furthermore, this statement is made in the nature of a preliminary report pending further observations. An agent of this nature, acting more or less comparably to heat or massage, can have value only when the conditioning circumstances are propitious and when the physiologic disturbance is not so severe or chronic as to resist all forms of therapy. That any influence of this nature, however, should ever be observed comes in the nature of a corroboration, from the clinical standpoint, of the precise laboratory observations recorded above.

As already stated, these observations on the blood sugar are not to be interpreted in terms of specific carbohydrate metabolism. Glucose has been estimated merely as the most available and suitable for study of many components of the blood which in theory might have been selected. In the light of this series of studies, the failure of removal of glucose is obviously to be referred to a failure of the blood adequately to reach some tissues, especially the muscles, where the removal of glucose normally and rapidly takes place. It is obvious, however, that some of the other blood components must also be affected in a comparable way, as is indeed shown by the failure of removal of oxygen in

5. Cajori, F. A.; Crouter, C. Y., and Pemberton, Ralph: J. Biol. Chem. **66**, (Nov.) 1925.

that blood showing the delayed removal of sugar. It is clear, therefore, that at least occasionally the muscles of the arthritic patient receive less blood as a whole than they normally should, and that therefore their physiologic function must at times be modified or perhaps much deranged.

This therefore affords some explanation of the frequency of muscular disability in the rheumatoid syndrome and the value of exercise and massage to it through the greatly increased blood flow thereby induced.

CONCLUSIONS

1. The present experiments form part of an attempt to explain the influence of focal infection and the pathologic changes of arthritis. They are in full consonance with the recognized rôle of infectious foci in many cases of arthritis and throw light on the mechanism through which foci exercise their effect.

2. Under suitable conditions of "load," the arthritic patients have been shown in 60 per cent of cases to remove certain constituents from the circulating blood, namely, oxygen and glucose, with less than normal rapidity. This phenomenon closely parallels the incidence of focal infection.

3. Among the 40 per cent of arthritic patients who do not show this delay, it has been induced, in respect to glucose, by interfering with the blood flow of the limbs in half of the cases studied.

4. This delayed removal is therefore present actually or potentially in 84 per cent of arthritic patients. It has not been induced so far among the few normal persons observed.

5. Among the 60 per cent of arthritic persons who spontaneously show this delayed removal, it can be restored toward normal in a majority of cases so far tested, by drugs, such as the nitrites, which induce vasodilatation.

6. These several observations can be explained at present only on the basis that arthritis is accompanied by a disturbance of peripheral blood flow, probably in the nature of vasoconstriction. This phenomenon is apparently an important result of focal infection and constitutes at least part of the pathologic process of arthritis. It explains the value of the many measures that improve the blood flow and metabolism in the arthritic or rheumatoid syndrome and allied conditions.

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General Practitioner Is Keystone of Medical Practice.—With the changes time has brought about, men in general practice who become the guide, philosopher and ultimately familiar friend of their patients, whom they bring into and see out of the world have also changed, for their medical education and general equipment have greatly improved. They have thus become less dependent on the help of specialists and consultants with whom to some extent they therefore compete. It has been thought by some that eventually general practitioners will become squeezed out by specialists and consultants, on the one hand, and, on the other hand, by preventive and social medicine, such as school, tuberculosis, and venereal clinics, and maternity and child welfare centers. But the general practitioner is the essential element in the medical service, and his elimination would be a most serious loss. Just as they have altered in the past so should they accommodate themselves to changing conditions, to a larger measure of team-work, to a greater share in preventive medicine and to take their part in public health organization.—Rolleston, Humphry: *Lancet* **2**:738 (Oct. 9) 1926.

HYPOPHYSECTOMY AND REPLACEMENT THERAPY

IN RELATION TO BASAL METABOLISM AND SPECIFIC DYNAMIC ACTION IN THE RAT *

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Within the last few years there have appeared several reports [1] to the effect that the specific dynamic action of food is decreased in so-called pituitary disease. No studies of this question appear to have been made on laboratory animals, though there are reports of lowered basal metabolism following surgical removal of or injury to the hypophysis (Benedict and Homans [2] in the dog, Winton and Hogben [3] in the frog). However, much of the work of these investigators is inconclusive on account of the ill defined nature of their experimental material as seen in the light of recent investigations of hypophysial function. The experimental work of Camus and Roussy,[4] Bailey and Bremer [5] and Smith,[6]

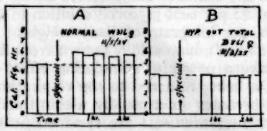

Chart 1.—Metabolism, in twenty minute periods, before and after intraperitoneal injection of glycocoll, 1.5 Gm. per kilogram in *A*, normal rat; *B*, hypophysectomized rat.

and the clinical cases of pituitary atrophy, reported by M. Simmonds [7] and others show that a pituitary deficiency does not give rise to obesity. Since most of the clinical cases, aside from the acromegalic subjects on which metabolism studies have been made, as well as the dogs used by Benedict and Homans,[2] displayed an adiposity it is certain that these were not cases of a pure pituitary deficiency but were complicated by injuries to the important vegetative brain center the tuber cinereum. From the type of operation used and from the reparative effects which are secured by pituitary transplants, it seems certain that the operation of Smith gives a pituitary deficiency uncomplicated by brain injury. It seemed worth while, therefore, to use some of the rats hypophysectomized by this method for studies on basal metabolism and specific dynamic action.

* Aided by grants from the Board of Research, University of California.

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METHOD

The metabolism data were obtained by the use of a closed circuit respiration apparatus which is adapted for short (twenty minute) periods. Numerous alcohol checks have convinced us that the apparatus (a description of which has been published by Foster and Sundstroem [8]), is sufficiently accurate for our purpose. The routine of a metabolism experiment is as follows: The rat, deprived of food for from twelve to eighteen hours, is placed in the respiration chamber. Usually within from thirty to forty minutes the animal comes to rest and sleeps. Two or three basal periods of twenty minutes each are obtained, after which the animal is

Chart 2.—Metabolism, as in chart 1, of hypophysectomized rat receiving replacement injections of *A*, posterior lobe only; *B*, both posterior and anterior lobe; *C*, anterior lobe only.

taken from the chamber and receives an intraperitoneal injection of 15 per cent glycocoll solution to the amount of 1.5 Gm. per kilogram of body weight. (Glycocoll was used, as this amino-acid is known from the work of Lusk to have a powerful stimulating effect on metabolism). On being returned to the respiration chamber the animal becomes quiet usually within thirty minutes, after which measurements are resumed in a series of twenty minute periods.

The animal chamber is kept at a constant temperature of about 29 C., at which temperature the rat soon becomes drowsy, and in general, with our animals, not much trouble has been encountered in keeping the subjects quiet. The observer, however, watches the animal and discards any period complicated by movements of the animal.

BASAL METABOLISM

The average of forty-four observations of basal metabolism (29 C. and no muscular activity) of normal rats was 4.8 calories per kilogram per hour (maximum, 5.7; minimum, 4.1), whereas in seven totally hypophysectomized animals which did not receive replacement therapy it was 2.8, 2.9, 3.1, 3.3, 3.2, 3.4 and 3.6. This remarkably low rate is apparently a consequence of removal of the anterior lobe of the pituitary as it is not manifest when only the posterior lobe is removed (chart 3). Moreover, the basal rate is within the normal range when the whole gland is removed, and the animal receives replacement transplants of anterior lobe only (chart 2 *C*), but not if the replacement therapy consists only of posterior lobe (chart 2 *A*). The low basal metabolic rate of hypophysectomized animals is also raised by thyroid injections.

It may be well here to call attention to some of the changes in the other endocrine organs following pituitary ablation, for we do not wish to indicate that our conclusions are that the anterior pituitary in itself, as appears to be the case with the thyroid, can stimulate the metabolic rate. Hypophysectomy causes an atrophy of several of the endocrine glands (thyroids, suprarenal cortex, gonads). This atrophy appears to be due to the deficiency of the anterior pituitary, for it does not occur with posterior pituitary ablation. Furthermore, in total hypophysectomy this atrophy can be largely prevented or a repair effected by anterior pituitary transplants but not by posterior pituitary administration. The low metabolic rate displayed by the hypophysectomized rat may be directly due, then, to a deficiency in the secretion of one of the other endocrine glands; the rise in the metabolic rate with anterior pituitary transplants may be due to the functional repair of this other gland. That such is probable is suggested by the fact, as mentioned above, that thyroid administration raises the metabolic rate in the hypophysectomized animals.

SPECIFIC DYNAMIC ACTION

Chart 1 *A* presents a typical experiment showing the reaction of the normal animal to the intraperitoneal injection of glycocoll (1.5 Gm. per kilogram). Following the injection of the amino-acid there is an average increase of about 15 per cent above the basal heat production over a period of three hours or more. Similar injections of physiologic sodium chloride solution do not affect the metabolic rate.

In the case of totally hypophysectomized animals, this specific dynamic action of glycocoll is entirely absent (chart 1 *B*). This fact is not surprising in view of the recent report of Baumann and Hunt [9] that specific dynamic action of glucose is absent in thyroidectomized rabbits (an observation which we have confirmed in unpublished work with thyroidless rats). As pointed out above, hypophysectomy causes profound atrophy of the thyroids. What is more remarkable is the observation that this failure of specific dynamic action of glycocoll seems not to be repaired by the daily transplants of anterior lobe substance (chart 2 *C*), a treatment that does repair the other disabilities induced by hypophysectomy. Nor is this defect repaired by daily injections of posterior lobe only

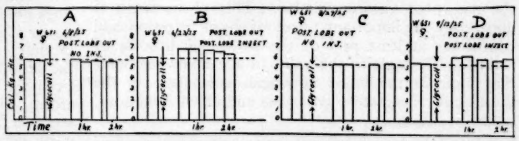

Chart 3.—Metabolism, as in chart 1, of rat deprived by operation of posterior lobe only, *A* and *C*, without replacement therapy; *B* and *D*, with replacement injections of posterior lobe extract.

(chart 2 *A*). It is only when replacement of both anterior and posterior lobe substance is made that the specific dynamic action is manifest (chart 2 *B*). This is substantiated by experiments of the type presented in chart 3, which represents the reactions of an animal from which only the posterior lobe was ablated. Here the basal metabolism was within the normal range, but glycocoll injections produced no specific dynamic effect except when the posterior lobe deficiency was abolished by daily injections of bovine posterior lobe extract. It is noteworthy that the posterior lobe injections do not repair the defect immediately, but only after being continued for several (from ten to fourteen) days.

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SUMMARY

The basal metabolism of totally hypophysectomized rats was found to be about 35 per cent below the average of our series of normal animals. The metabolic rate of these animals may be restored to normal by daily anterior pituitary homotransplants or by daily injections of thyroid extract, but not by daily injections of posterior lobe extract.

The specific dynamic action of glycocoll is absent in hypophysectomized animals and apparently can be restored only by replacement of both anterior and posterior lobe, but not by either one alone.

PHYSIOLOGIC CONSIDERATIONS IN THE TREATMENT OF OBSTRUCTIVE JAUNDICE*

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The more common lesions of the biliary tract complicated by obstructive jaundice are stones in the common bile duct, empyema of the gallbladder with cholangeitis, stricture of the common duct, and tumors of the head of the pancreas, usually carcinomatous, rarely inflammatory. In this group, relief of the obstruction and removal or drainage of the infected gallbladder, when such is indicated, is followed by recovery unless the obstruction is the result of a carcinoma at the head of the pancreas. In the latter condition, although the patient eventually dies from the malignant disease, an anastomosis between the distended gallbladder and the intestine allows the distended biliary tract to empty; jaundice disappears and the itching, so often the only distressing symptom in this group of cases, is relieved.

General functional impairment of the body and tissues in patients with obstructive jaundice is evidenced by the loss of weight and strength, the tendency to diarrhea in some cases, and prolonged coagulation time of the blood. From celloidin-corrosion preparation of the liver and biliary tract, Counseller and McIndoe [1] have been able to demonstrate the changes induced in the biliary and vascular tree by biliary obstruction. They have demonstrated the rapid dilatation of the extrahepatic and intrahepatic branches of the biliary tree resulting from obstruction by carcinoma at the head of the pancreas, in contrast with the slow dilatation that occurs when the obstruction results from biliary calculi or stricture. In cases of stone and stricture, the delay in establishment of dilatation is due to the intermittent nature of the obstruction and to the limiting action of concurrent, quickly established, chronic cholangeitis. Dilatation of the intrahepatic branches of the hepatic ducts has been called hydrohepatosis by Rous. Counseller and McIndoe, carrying their work further, have found that, when hydrohepatosis is set up by biliary obstruction, the dilatation of the bile ducts is more prominent in the left lobe of the liver than in the right. This they attribute to the constricting effect of dilating bile ducts on the left branch of the portal vein, which is more slender and comes off at a more acute angle than the right. A vicious circle, they believe, is established in which the decrease in the portal blood flow causes in turn atrophy of the substance of the liver and more marked dilatation of the bile ducts of the left lobe. This is in accord with the work of Hinman and Hepler [2] on hydronephrosis in which partial ligation of the renal artery, together with ligation of the ureter, caused a greater degree of hydronephrosis than simple ligation of the ureter. Whatever the cause may be, acute or chronic cholangeitis frequently occurs in dilated ducts containing static bile. In the benign cases, with stones or stricture, this cholangeitis is usually of a chronic nature, but may and frequently does become acute. In the carcinomatous group, suppurative cholangeitis is often found at necropsy in some cases in which the obstruction had become complete. Impairment of the liver, because of obstruction, occurs from the beginning; in the cases of carcinoma it may be functional, while in the benign cases cirrhosis plays a very prominent part.

Considerable progress has been made in the preparation of patients with obstructive jaundice for operation. This preparation permits a preliminary period of study with concentration on that group of patients which would seem to be most benefited by surgical treatment. The results of preliminary study and preparation have been found to overbalance the effect of delay. When bilirubinemia is increasing or decreasing, surgical intervention is withheld until a level is reached. Patients whose jaundice has occurred subsequent to an attack of abdominal pain respond best to surgical treatment. In the determination of the advisability of operation in patients with painless jaundice, carefui stock should be taken and a balance struck between the expected benefits and risks of operation. In cases of uncertainty, with painless jaundice, a lapse of time may clarify the diagnosis and assist in the formulation of a decision in this respect.

In the study, five years ago, of the causes of mortality following operations in the presence of obstructive jaundice, it was noted that, in more than 70 per cent of the cases in which death was caused by hemorrhage, the preoperative blood coagulation time, determined by the method of Lee and White,[3] was more than nine minutes. Continuing the work begun by Hallenbeck and Giffin [4] in the preparation of jaundiced patients for operation, Bell and I began using intravenous injections of calcium chloride, and found that this afforded a safe and effective means of lowering the blood coagulation time of jaundiced patients in practically all instances. Lee and Vincent,[5] years previously, had demonstrated experimentally that intravenous injections of calcium lactate lowered the coagulation time of animals with obstructive jaundice. In the few instances in which intravenous administration of calcium chloride does not lower the coagulation time, blood transfusion may sometimes be beneficial.

Bowler and I,[6] studying the toxicity and rate of excretion of calcium chloride in dogs, found the lethal dose to be more than forty times greater than that used in

* From the Division of Surgery, Mayo Clinic.
* Read before the American Gastro-Enterological Association, Atlantic City, N. J., May 3, 1926.

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the preparation of patients for operation. Five cubic centimeters of a 10 per cent solution of calcium chloride given intravenously for three days prior to operation is a more easy and convenient method than the administration of a greater amount of a more dilute solution. The solution is meant for injection intravenously, and when injected subcutaneously is irritating and may cause sloughing. Seelig [7] has reported two such cases. This does not occur if care is taken to make certain that the calcium chloride enters the vein. In the several hundred cases in which three injections of 5 cc. of a 10 per cent solution of calcium chloride were given prior to operation at the Mayo Clinic in the last four years, I know of only one case in which a slough occurred, and that only because the solution missed the vein. The results following the use of calcium chloride are reflected in the fact that, in 179 operations on the common and hepatic ducts during 1925 at the Mayo Clinic, there was only one instance of intra-abdominal hemorrhage causing death. Sixty-eight of the 179 patients were jaundiced at the time of operation. The diet administered contains a preponderance of carbohydrates, augmented when necessary by glucose, in order to supply what is lacking as a result of disordered function of the liver. An abundance of fluids, usually 3,000 cc. each day, overcomes dehydration. If the patient cannot drink this amount, it can be given conveniently by proctoclysis or as physiologic sodium chloride solution injected subcutaneously.

McVicar and Weir,[8] under whose care these patients are now prepared for operation, have used duodenal drainage by the Lyon method for diagnosis. This method is more precise than examination of the stool, and gives a better idea of the quantity of bile flowing into the intestine. In painless jaundice, a free flow of bile argues against a pancreatic tumor and favors the probability of intrahepatic obstruction. Little difference in the flow of bile followed the use of warm water, magnesium sulphate, or oleic acid in the experience of McVicar and Weir. We have relied on the van den Bergh [9] method of quantitatively determining the bilirubin content of the blood serum to index the fluctuation of jaundice. In clinical and experimental studies of obstructive jaundice, Greene, Snell, McVicar, Rowntree and I [10] showed that the bilirubin content of the blood inversely paralleled the excretion of phenoltetrachlorphthalein from the blood stream. Evidence of the clinical value of the van den Bergh test has been emphasized by Judd,[11] de Takats [12] and Müller.[13]

After an extensive review of the literature concerning bile pigment, Rich,[14] in 1925, concluded that the site of formation of bilirubin had not been demonstrated and that hemoglobin was the only known material from which bilirubin could be made. More recently, Sheard, Baldes, Mann, and Bollman [15] have presented a series of studies on the formation of bilirubin, made by means of the spectrophotometer. This instrument is so sensitive that it determines the presence of bilirubin in a dilution of 1:100,000,000 with accuracy. The method depends on the examination of solutions prepared from the blood for the determination of the absorption of specific wave lengths of light in transit through them. In general, these authors found that the bilirubin content of the blood from arteries is uniform at any one time and that blood obtained from the renal or mesenteric veins contains the same amount of bile pigment as arterial blood. On the other hand, a greater concentration of bilirubin was found in blood returning from the extremities in the femoral vein than in that going to them through the femoral artery. A similar increase was found in blood coming from the spleen. Following the experimental production of obstructive jaundice, it was further noted that there was a greater concentration of bilirubin in the blood of the hepatic vein than in that of the hepatic artery. They concluded that the principal site of the formation of bilirubin is in the bone marrow, but that it is formed in the spleen and liver as well.

After ligation of the common bile duct and exclusion of the gallbladder, an abnormal amount of bilirubin appears in the blood within ten minutes, and its increase is remarkably constant for several hours. If, during this period, laked blood is injected intravenously, a marked acceleration in the rate of increase of bilirubin occurs, developing within thirty minutes after the injection of the laked blood and continuing as long as free hemoglobin remains in the circulation. This, Sheard and his associates believe, also demonstrates that hemoglobin is a source of bilirubin. Interesting in this connection is the almost constant secondary anemia that accompanies obstructive jaundice.

STONES IN THE COMMON BILE DUCT

Jaundice following biliary colic, in cases in which no previous operation on the biliary tract has been performed, is usually the result of one or more stones in the common bile duct in addition to any concomitant disease in the gallbladder. Although patients with stones in the common bile duct have, for the most part, had jaundice at one time or another following an attack of biliary colic, yet about 30 per cent of them will not appear to be jaundiced when they are examined. The bilirubin content of the blood serum in such instances is frequently increased, as shown by the van den Bergh test. All operations on the biliary tract should include careful examination of the common bile duct, pancreas and liver, as well as the gallbladder. In the majority of cases, stones in the common duct can be readily felt; yet, not infrequently, a single stone of the ball valve type of Fenger,[16] floating in the ampulla, may be overlooked unless the common duct is opened and explored with a scoop. When one or more stones are present in the common bile duct, the latter is usually dilated from a diameter of 0.5 to 0.8 cm., or even to as large as 1.3 cm., and the bluish green, thin wall of a normal common bile duct becomes thickened and

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whitish. The results following the removal of a diseased gallbladder and stones from the common or hepatic ducts are excellent, and with methods of rehabilitation prior to operation the mortality of surgical treatment in these cases has been greatly reduced.

EMPYEMA OF THE GALLBLADDER

Empyema of the gallbladder, accompanied by inflammation and edema of the adjacent common and hepatic ducts and liver, is often severe enough to produce moderate jaundice following biliary colic. In these cases, the drainage or removal of the diseased gallbladder suffices to relieve the patient, provided no stones are present in the common or hepatic ducts. When debility and infection make the risk of cholecystectomy great, cholecystostomy may be preferable.

STRICTURE OF THE COMMON HEPATIC DUCT

Although stricture of the common hepatic duct results occasionally from syphilis or extensive duodenal ulcers, it is most commonly caused by injury to the common or hepatic ducts during the removal of the gallbladder. The presence of extensive drainage material and postoperative infection at the operative site are given by Judd and Burden [17] as other causes of postoperative stricture of the common or hepatic ducts. In these cases bile usually drains for a considerable time, usually weeks after the first operation, and jaundice sets in after the cessation of biliary drainage. Biliary colic may or may not be present, and chills and fever are not infrequent. It is difficult at times to make a differential diagnosis between a stone in the common or hepatic duct and a stricture until the ducts are examined at operation. Strictures of the common duct can be excised and, by anastomosis of the stump of the common or hepatic duct to the duodenum, relief of the obstruction can be accomplished. The use of a catheter, as advised by McArthur,[18] affords a scaffolding over which the anastomosis is made and a channel through which the bile may enter the intestine. The catheter is maintained in position by a long silk thread attached to the surface of the skin. When the catheter has served its purpose, the silk thread is removed, and intestinal peristalsis carries the catheter through the intestine to be passed with the stool. If care is taken to see that the mucous membrane of the common or hepatic duct is accurately anastomosed to the mucous membrane of the duodenum, as described in 1905 by W. J. Mayo,[19] the results are excellent. Several cases of this type, followed for a number of years, have shown complete relief of symptoms.

PANCREATIC OBSTRUCTION

Tumors in the head of the pancreas may be the result of pancreatitis or carcinoma. Moynihan [20] has said that it is impossible to distinguish between them, even at operation. This has led to the adoption of a method of short-circuiting the bile from the distended gallbladder into the intestine by cholecystenterostomy. Whether the lesion is pancreatitis or pancreatic carcinoma, bile reenters the intestinal tract, jaundice subsides, itching ceases, and marked improvement in the patient's general condition occurs. If the obstruction has been the result of pancreatitis, the patient's recovery is permanent; if the result of malignant neoplasm at the head of the pancreas, jaundice and itching are relieved. In previous years, cholecystenterostomy in the presence of deep jaundice was attended by considerable risk from hemorrhage, but the use of intravenous injections of calcium chloride and the accurate ligation of the ends of the enlarged veins in the wall of the distended gallbladder have reduced the operative risk to within reasonable limits.

As a rule, jaundice from pancreatic obstruction is painless. The jaundice of pancreatitis may be intermittent, while that of carcinoma is usually constant and progressive. Although pain does not usually exist in either case, it may occur. In cases of obstruction resulting from pancreatitis, periods of fever may accompany the jaundice. A palpable gallbladder assists in locating the obstruction in the head of the pancreas.

HEPATITIS, CHOLANGEITIS AND BILIARY CIRRHOSIS

At the present time, we are particularly interested in a group of cases in which jaundice, occurring insidiously without pain, and lasting for months or even years, usually varying in intensity, is due to hepatitis, cholangeitis or biliary cirrhosis. The problem in this group is twofold: the differential diagnosis of extrahepatic obstruction removable surgically, and the treatment after diagnosis has been made. The fact that stones in the common bile duct or pancreatitis, conditions responding readily to surgical treatment, may produce the same symptoms, even to the absence of pain, attaches great responsibility to a diagnosis of cholangeitis, hepatitis or biliary cirrhosis, and a refusal of the opportunity of an abdominal exploration. On one or two occasions, I have operated after a diagnosis of cholangeitis or hepatitis, to find and remove a "silent" stone in the common duct or to discover a tumor at the head of the pancreas; an anastomosis of the gallbladder to the intestine sufficed to relieve the jaundice. The corollary of this is that patients with obstructive jaundice who can be prepared for operation, when there is doubt concerning the diagnosis, should not be denied the advantage of an exploratory operation, particularly since the method of preparation makes the operation practically as safe as it is in cases of disease of the biliary tract, uncomplicated by jaundice.

POSTOPERATIVE COMPLICATIONS

Postoperative complications are infrequent in jaundiced patients if they have been prepared before operation, provided the biliary obstruction has been adequately relieved at operation. It has been found that in 50 per cent of the cases in which death follows operation for stones in the common duct, a stone, overlooked in the biliary tract, has reobstructed the duct; jaundice deepens, uncontrollable bleeding takes place, or death follows renal or hepatic insufficiency. Such complications can be avoided.[21]

In 1922, Parham and I described a syndrome that occurred after operations on the biliary tract. The bile became paler and thinner, and increased in amount. The patient became pale and apathetic; the urinary output and blood urea remained normal. The syndrome was attributed to hepatic insufficiency. Intravenous injections of glucose have been of considerable value in the treatment of this type of postoperative complication, as reported by Judd and Snell. McVicar, using McArthur's method of introducing glucose into the

17. Judd and Burden (footnote 11, second reference).
18. McArthur, L. L.: Repair of the Common Bile Duct, Ann. Surg. **78**: 129-137 (Aug.) 1923.
19. Mayo, W. J.: Some Remarks on Cases Involving Operative Loss of Continuity of the Common Bile Duct with Report of a Case of Anastomosis Between Hepatic duct and Duodenum, Ann. Surg. **42**: 90-96, 1905.
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21. Walters, Waltman; and Parham, Duncan: Renal and Hepatic Insufficiency in Obstructive Jaundice, Surg. Gynec. Obst. **35**: 605-609 (Nov.) 1922.

intestinal tract by a tube in the biliary tract, recently administered glucose to a patient with an abnormally functioning liver. The T-tube, which had been placed by the surgeon in the common duct at operation, after the removal of a stricture, was used for the intestinal feeding; the patient recovered. In this case, as in one of my own, there was a normal concentration of chloride and urea in the blood, in contrast to the cases of duodenal fistula in which decrease of the chlorides is progressive, accompanied by a rise in blood urea.

TREATMENT OF PERNICIOUS ANEMIA

A PATIENT WHO RECEIVED ONE HUNDRED AND THIRTEEN TRANSFUSIONS *

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AND
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During the treatment of a patient for pernicious anemia, several unusual observations were made. He received 113 transfusions in three years from many donors. Slightly more than 52 liters of unmodified and modified blood was given to him by five methods without his developing unusual antagonism against any of the blood transfused.

REPORT OF OBSERVATIONS

History.—A small, spare man, aged 65, exhibited the signs and symptoms of typical pernicious anemia. He had been failing for less than six months, possibly for only four months. Age, wretched teeth, failure to comply with the Eighteenth Amendment and overexertion were possible contributory factors, but, as other and more serious similar offenders escaped, none of these could be held responsible. The occurrence of a similar condition in three other members of his immediate family indicated an inherent weakness of blood-forming structures. Blood counts and gastric analyses were characteristic of anemia. The central nervous system was not involved, and the digestion was little, if at all, impaired. Weakness, tachycardia and dyspnea were the chief complaints.

Advanced myocardial degeneration compelled rest in bed for sixteen days preparatory to splenectomy. In this interval, five transfusions were given. The spleen was then removed and the wound drained. The drain tract healed slowly, and inflammation recurred in it at intervals for months. Hemolytic streptococci were obtained in pure culture.

The patient was exceptionally obstinate and refused to follow directions to have his teeth removed, observe hygienic regulations, or to return for transfusion. As soon as he felt stronger he did as he pleased, and evaded transfusion until weakness compelled a period of compliance. Each time, a series of transfusions brought a fair measure of recovery until the last, and then, though the blood count could be improved, he was beyond relief; transfusions were discontinued and the end came peacefully.

Attention is directed to two series of transfusions with preserved blood. Feb. 18, 1925, 650 cc. of group II blood was preserved; 100 cc. was given the second day, 50 cc. on the third, fifth, seventh and ninth days, and 100 cc. on the fourteenth, fifteenth, sixteenth and seventeenth days after preservation. No untoward effects were noted and the patient's condition remained stationary. Sedimentation tests were not made. Again, beginning December 18, 100 cc. of preserved blood was given on the second, fifth and seventh days after preservation. The condition remained stationary. December 28, 650 cc. of unmodified blood given with a syringe led to improvement. On the second day following this transfusion, 150 cc. of preserved blood was given, and 400 cc. on the fifth and seventh days, leading to decided improvement. Indeed, two days later the blood picture simulated a secondary anemia, with a color index of 0.65. It is significant that just at this time the patient's blood showed a normal sedimentation rate. Later, the rate became more rapid and when last taken, ten days before death, it had become distinctly abnormal and ominous.

The use of preserved blood kept in cold storage for repeated small transfusions suggests the possible use of this method, if it proves safe, in treating patients less seriously affected, particularly when a large number of suitable donors is not available. Apparently the improvement of the oxygen-carrying power of the blood, which can be effected by introducing erythrocytes alone, is advantageous if the patient is not suffering from obvious intoxication that requires unmodified blood for relief.

Morbid Anatomy.—The spleen, removed, Feb. 21, 1923, was normal in gross appearance and weighed 300 Gm. Thromboendarteritis, hypoplasia of the malpighian corpuscles, increase in stroma, separation of open and empty blood sinuses and infiltration with eosinophils were noted during microscopic examination. The minute alterations were suggestive of Banti's disease.

Other observations made at necropsy, limited to the abdomen after the body had been embalmed, Jan. 30, 1926, are as follows:

The liver was normal in size and of a peculiar brownish color; there was chronic passive congestion, but the bile tracts were normal. Rich deposits of pigment were present in large granules in the cells of Glisson's capsule and in those of Kupffer, and in smaller granules in the parenchyma cells. There was slight chronic perihepatitis, but no cirrhosis.

The retroperitoneal and mesenteric lymph glands were normal in size and were yellowish. They contained many cells resembling bone marrow types, eosinophilic myelocytes and megakaryocytes.

The kidneys showed a slight chronic nephritis and terminal degenerations. The tubular epithelium contained great numbers of small granules of brown pigment.

Pigment was present in the pancreas in considerable amounts in cells of the stroma, acini and islands of Langerhans.

The gross appearance of the stomach and intestines was normal. There was considerable lymphocytic infiltration of the gastric mucosa which was otherwise negative, and almost without pigmentation.

The interstitial cells of the suprarenal contained a moderate amount of pigment.

The bone marrow of the femur was brownish red; fatty marrow was absent. Microscopically, the hematopoietic marrow was composed almost entirely of large irregular cells two or three times the size of neutrophilic leukocytes. The majority were well filled with dark brown iron-containing pigment. Some particles of pigment were as large as or even larger than erythrocytes. Besides the pigment, many of these cells had engulfed unnucleated red blood corpuscles. Most of these cells resembled the precussors of myeloblasts, which were present in small numbers. Cells of the lymphocytic series were in the minority. A few neutrophilic leukocytes but no nucleated red cells were present. The bone marrow of the rib was identical except for less pigment.

All of the pigment gave the characteristic reaction of iron-containing pigment.

The anatomic diagnosis was pernicious anemia.

SUMMARY

No other patient has received, so far as is known, the number of transfusions here recorded. This man required a transfusion of 500 cc. of blood every two weeks to provide sufficient internal respiration to maintain active life. Several times during his illness he refused transfusion for periods of from four to six weeks, but was compelled by his waning health to return for more blood. Each time it became more difficult to restore him, even approximately, to his previous status. He refused to follow directions as to diet, rest and general hygiene, nor would he permit the removal of his

* From the Columbia Hospital.

teeth. The fatal decline followed an interval of five weeks without transfusion. Despite his noncooperation, his life was apparently prolonged two or more years, which gained for him opportunities for enjoyment and accomplishment.

The patient belonged to group II, Moss classification. He was given unmodified blood by paraffined Kimpton tubes and divers syringes, blood modified by sodium citrate and lithium citrate and blood preserved according to the method reported by Margaret Perry.[1] He received blood from donors of both groups II and IV. Group IV donors were used over a considerable period following the suggestion of Winifred Ashby that such blood persists longer than that of the patient's own group (II or III). Because of the frequency of transfusions, it was impossible to determine how long group IV cells remained in his circulation. Several times during the interval in which group IV blood was given exclusively and while the hemoglobin was between 70 and 80 per cent (Dare) it was demonstrated by Ashby's method that three fourths of the erythrocytes in circulation belonged to group IV. The patient lived on blood, 75 per cent of which was donated. The erythrocyte counts ranged about 4,000,000, so that under most favorable conditions he could maintain only 1,000,000 red cells of his own production in circulation.

During his illness it was impossible to recognize positive or negative phases. He felt better and worse at times, and when he felt better he declined transfusion with the same result, intensification of the anemia. The incompetence of the majority of the erythroblasts had progressed beyond fatigue into permanent exhaustion before treatment was begun, else some rehabilitation would doubtless have been obtained and a remission would have occurred.

Discussion will be limited to the relative merits of transfusions of modified and unmodified blood, given more frequently in smaller amounts or in larger volumes at longer intervals, as a means to combat the permanent incompetence of at least three fourths of a patient's erythroblasts. This man was peculiarly sensitive to citrated blood; his reactions were sharp, the chills and fever were prostrating, and subsequent benefits from nonspecific protein reactions were notably absent. Lithium citrate proved to be decidedly less noxious than sodium citrate, equally efficacious in preventing coagulation, and therefore preferable. Preserved blood is troublesome to prepare, but it was given without untoward effect to this patient and with excellent results. Unmodified blood, particularly that given with the paraffined tubes, was harmless, and to that extent at least the most beneficial. Veins suitable for this procedure were ultimately destroyed. The syringe method provided an excellent substitute.

It appears that the more efficacious means to meet existing conditions varied with those conditions. Larger, more infrequent transfusions at times worked well. At others, a few massive transfusions to restore the blood volume, and followed by diurnal or biurnal administrations of preserved blood to replace the deficits of these intervals, obtained the nearest approach to optimal conditions. The refusal of the patient to cooperate for more than short intervals made it impossible to determine the means to provide the largest benefits.

The Cloughs[2] reported that a patient suffering from pernicious anemia developed such antagonism against transfused blood after a series of fourteen transfusions that compatible blood could no longer be found. Careful tests failed to demonstrate in vitro any incompatibility between the cells and serums of donors and patient; yet the latter developed violent reactions after transfusions. The sole obvious difference between the patient reported by Clough and the one here recorded is that the spleen of the latter had been removed. Should this be the explanation of a failure to develop intolerance to donated blood, it is an indication for splenectomy that has not previously been advanced.

The amount of pigment deposit was many times the amount found in tissues from individuals dying of pernicious anemia. This probably resulted from gradual destruction of the large amount of transfused blood.

CONCLUSIONS

A man, aged 65, was so incapacitated by increased blood destruction and decreased blood construction that he was able, even when aided by transfusions, to maintain in circulation only a fifth of the normal number of erythrocytes.

Notwithstanding permanent reduction of the competence of the erythroblasts to one-fifth normal, a fairly active life was prolonged two years by repeated transfusions. Had this patient been willing to follow directions and conserve his energies, his life would have been extended further.

Death resulted from failing metabolism, the fatigue and exhaustion of cells whose functions were essential to life, which had been injured by the restricted oxidation during periods of intense anemia, by overexertion and perhaps by intoxication.

Transfusions are the surest and quickest means to aid the rehabilitation of erythroblasts fatigued in the courses of secondary anemias, and to induce the intervals of recoveries of competence in primary anemias which may last for years.

The experiences of this patient indicate that restoration of the blood volume to normal by several large transfusions, and the maintenance of a relatively normal blood volume by repeated small transfusions to offset the deficit in hematopoiesis provides opportunities for such recovery as may be obtained, and assures the utmost extension of active life.

The use of preserved blood, if it proves to be safe, offers a means to provide for frequent small transfusions.

It may be that intolerance of donated blood acquired after repeated transfusions can be obviated by splenectomy.

141 Wisconsin Street.

1. Perry, Margaret: Wisconsin M. J. **25**: 123 (March) 1926.
2. Clough, P. W., and Clough, M. C.: Southern M. J. **14**: 104 (Feb.) 1921.

Hypersensitiveness in Children.—According to Craig, the importance of hypersensitiveness in the child can scarcely be overestimated. It leads to an unhealthy emotional reaction and to such other undesirable habits as preoccupation, introspection, and prolonged or repeated excursions into the realm of phantasy, and in general disturbs the relationship existing between the child and his environment. In consequence, a loss of adaptation appears, and the inferiority idea so emphasized by Adler is given a place of prominence in the mental life. . . . We should always remember that the spirit of the child exceeds his power of physical endurance, and that if he is not controlled he may be overzealous at work or play, become overstimulated, and show a reaction of hypersensitiveness. . . . Underlying all successful treatment is the acceptance of the fundamental principle that each child is an independent personality to be respected and treated with courtesy and consideration.—Pritchard, J. A.: The Psychiatrist and the Preschool Child, *State Hosp. Quarterly*, November, 1926.

REDUCTION OF MORTALITY AND MORBIDITY IN CHILDBIRTH

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Statistics show that the mortality among child-bearing women generally greatly exceeds that shown in the practice of careful and competent men or that recorded by well supervised clinics. Childbirth is so common a phenomenon and is experienced by so many without mortality or apparent morbidity that the lay public is always surprised when cautioned concerning the dangers (immediate or remote) of childbirth; and those of a lesser degree of intelligence, or with a lessened sense of responsibility, have been apt to look on the physician warning them as an alarmist, and have paid less attention to his warning than was consistent with safety. While this condition is passing to some extent among thinking people, it is unfortunately true that the majority of the public do not belong to this class and need to have brought to them in some way the hazards of child bearing in neglected cases, and the comparative freedom from danger in cases well cared for.

The great need is to dicuss methods of bringing to the laity the knowledge which is available for the prevention and relief of the complications of childbearing, and the prevention of the mortality and morbidity thereby arising.

How are we to reach the lay public? Are we to reach it through the physician and the visiting nurse, or are we to go directly to the laymen themselves?

If we are to take the message to the physician, what message shall we take? How shall we determine what part of the work belongs to the visiting nurse, and if we go to the laymen, how shall we reach them and what shall we tell them?

Before entering on therapeutic discussions, one should have clearly in mind what conditions are the causes of the mortality and morbidity of childbirth. Most of these are well known, but a great trio stand out most prominently as the cause of more than half of the maternal deaths. De Lee states that out of 25,000 maternal deaths each year in the United States, 6,000 result from infection, 5,000 from eclampsia and 4,000 from hemorrhage. It is as certain as anything can be that the great majority of these deaths can be easily prevented.

In the smaller towns in Maryland, we have been giving to groups of physicians and nurses a series of six lectures of an hour each—six lectures to each group. These lectures are given under the auspices of the bureau of Child Welfare and the extension work of the University of Maryland. Interest has seemed to be fairly aroused where the lectures have been given and the attendance is encouraging, numbering about an average of twenty-five in the smallest group and seventy in the largest. In these lectures, which were primarily for physicians, we have tried to emphasize the need of having patients report early and frequently to the physician, and the need of a simple but careful record of each case. We try not to discourage the physician in this regard by asking him to keep too elaborate a record, but show him that a card 5 by 8 inches written on both sides will hold all the absolutely necessary data in each case. We try to impress on him the essential requirements: a record for birth certificate, the history previous to marriage, the history of previous pregnancies and the present pregnancy, and the relative value of various facts found. In the previous personal history, the importance of tuberculosis and cardiac trouble, severe scarlet fever, rheumatism, chorea, nephritis, and in the obstetric history, such facts as miscarriage, forceps deliveries, toxemias, hemorrhage, stillbirths, infections and cesarean section must be noted and their full significance ascertained. In the obstetric history, we ask them to obtain not only the facts concerning abortion, forceps deliveries, and the like, but to ascertain their sequence. A history, for instance, that gives a record of a miscarriage in the first pregnancy, followed by one or two normal pregnancies and labors is not so important as one that records a normal pregnancy followed by one or two miscarriages; and, again, a first labor terminated by forceps and followed by subsequent spontaneous labor is a very common occurrence, while, on the other hand, one or two labors terminating spontaneously, followed by forceps deliveries in subsequent labors, may have a profound significance. Why was a cesarean section done? A stillbirth in a forceps delivery in a primiparous woman may have little significance, but a stillbirth in a multiparous woman following the birth of normal healthy children needs very careful consideration. We particularly urge physicians to ascertain carefully the cause of stillbirths.

A history is worth nothing if its worth cannot be determined; its worth can be determined only by an intelligent correlation of the facts ascertained or ascertainable.

We further insist on a careful physical examination, with especial consideration of the abdominal tumor and pelvis, the size and shape of the uterus, measurements and characteristics of the pelvis, and palpation of the fetus to ascertain its attitude, presentation and position. The prospect for a satisfactory delivery is much better in the case of a woman whose contracted pelvis has been measured, the probability of a spontaneous labor carefully considered, and preparation for operative delivery made beforehand.

We emphasize the need for careful advice about exercise, diet, clothing, sexual intercourse, constipation, etc., and we urge that the patient receive very careful instruction to report such conditions as headache, constipation, edema, hemorrhage of the slightest degree or pain, and to return at regular intervals. We try to show the physician that from five to ten minutes is sufficient for most of the subsequent visits, and that the whole matter of records and prenatal supervision takes much less time than they have supposed.

We then insist on the instruction of the patient in the matter of preparation for labor, urging, in the matter of supplies, simplicity and economy, but emphasizing the necessity for cleanliness, and in the selection of a delivery room sunlight, proximity to water, and as much isolation as possible. We stress also, the great advisability of cooperating with the county visiting nurse in these preparations.

We, of course, urge the necessity of scrupulous cleanliness during delivery, the use of rubber gloves, the fewest possible vaginal examinations, the inadvisability of attempting to do operative deliveries alone, and the necessity for consultation, when available, in all complicated cases.

We urge care in matters of early rupture of the bag of waters, the use of pituitary extract, and too early intervention in uncomplicated cases; in the too early

or too vigorous attempts to express the placenta (the most frequent cause of postpartum hemorrhage), and in the immediate repair of the injured perineum. We advise physicians to insure their patients quiet, rest and sleep; absence from worry during the puerperum, and cleanliness both of the nipples and perineum; to make regular visits, in the afternoon, if possible; to ascertain the temperature and pulse at each visit, and to urge regular nursing of the child and avoidance of too early a return to work.

We then discuss the pathology of pregnancy, beginning with abortion and extra-uterine pregnancy, giving important differential points, and urging absence of intervention in the one and immediate intervention in the other.

We insist that continued bleeding of considerable amount over a period of several days during early pregnancy is in all cases a satisfactory reason for intervention.

We emphasize the ease with which the diagnosis of placenta praevia is made and the necessity for immediate intervention, giving the differential diagnosis between that and premature separation of normally implanted placenta, and urging immediate treatment here. In these cases, we impress as forcibly as possible that from first to last the chief duty of the physican is to conserve the blood of the patient, not only for the immediate benefit to the patient, but because a patient who has lost blood is a poor surgical risk and is prone to infection.

In the toxemic group, we try to show that in pernicious vomiting nearly all, if not all, such cases are neurotic in character, and that all may be cured if handled firmly; that practically all cases of eclampsia are preventable, and that if any patient becomes toxemic in spite of treatment, careful supervision of the patient will discover symptoms of preeclampsia in time for the induction of premature labor; that nephritic patients should not become pregnant, as they are prone to produce premature, puny or dead children, and in the bearing of them do themselves infinite injury.

In the group of infections which occur both in the abortions and during labor and puerperium, we try to teach that unwarranted intervention by curettage in abortions and too frequent vaginal examinations in labor are the chief causes. If physicians and midwives learn to be clean and to avoid intervention, the matter of infection will largely be solved; not entirely, of course, as there are cases in which the greatest care has been exercised under ideal conditions, and patients have later died of infection. Cases of auto-infection cannot be entirely ruled out, and improper handling of herself by the patient is sometimes responsible, but these are only a small percentage of all cases.

To the nurse, we can urge careful and tactful supervision of all cases coming under her supervision. The laywoman will frequently place more confidence in the instruction of the nurse than in that of the physician, and certainly when she has had a chance, the social service or prenatal or maternal welfare nurse has justified her employment. But, it is urged with truth, much of this already has been done, and the mortality has not been materially reduced.

It is my opinion that the best results are not going to be obtained through the further education of the physicians and the efforts of social service nurses, valuable as this instruction may be, but must come through the efforts to bring the facts directly to the laity—to women's clubs, to church societies, and to political groups of women. And indeed, not to laywomen alone, but to laymen the gospel must be preached that the child-bearing woman is the most important member of the community; that the greatest tragedy that can possibly occur is the death of the actual or potential mother of a family, who was, perhaps only a few days, or possibly a few hours before, apparently in good health, and that this need not occur. If the neglect which has been the portion of the child-bearing woman is brought home, if it can be shown to her, and she can once be persuaded that the mortality her sisters have suffered and the morbidity which she herself suffers is the result of improper supervision during pregnancy and improper care during childbirth, she will demand decent supervision and care; and when she does, she will get it, because no physician will long survive in an intelligent community of women aware of their rights who does not furnish the kind of care they demand.

Proper education of the lay public in prenatal care and efficient methods of delivery will certainly largely reduce the number of deaths from infections and will almost entirely prevent deaths from eclampsia; it will reduce deaths from nephritis and from placenta praevia, the hardest of all conditions to control. I have not mentioned the cardiac cases. No more brilliant results can be shown than can be obtained by careful prenatal supervision of this group, and no more unfortunate results are shown than those that occur in neglected cases of this group.

The conditions mentioned do not cover all that might be considered—cases complicated by acute infectious diseases, surgical complications, unrecognized pelvic diseases and many others. Time does not permit discussion of them; certainly there are none of them in which intelligent appreciation of their relation to pregnancy, and the early application of intelligent care could fail to improve the mortality incident to them.

Much good could be done through instruction to the physician and the nurse, but the great advance, in my opinion, will come through an approach to the laity, and it is my advice that our efforts should be concentrated in that direction.

SUGGESTED PROPAGANDA TO THE LAY PUBLIC

It ought not to be difficult to bring to laywomen everywhere a few very important facts; namely, that:

1. Childbearing in this stage of our civilization is no longer necessarily a physiologic process.

2. Pregnant women should report to the physician as early as the condition is known.

3. Careful supervision at relatively short intervals is necessary to prevent many of the complications of pregnancy and childbirth.

4. The physician who does not desire to do this for his patient is not considerate of her welfare.

5. Headache, edema, constipation or hemorrhage of any degree mean trouble if not relieved.

6. Routine examination of the urine and routine blood pressure measurements should be a part of the examination at each visit.

7. Careful physical examination, including examination of the pregnant uterus, and measurement of the pelvis are necessary.

8. Careful preparation for delivery frequently saves trouble in labor.

9. The physician who wants no record of the patient's history, who does not require her to visit him regularly and who does not wish to know anything about her until she is in labor is not the physician who should attend her.

THE STONELESS GALLBLADDER

A STUDY OF POSTOPERATIVE END RESULTS

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The many large series of gallbladder operations reported in the literature all show high percentages of cases in which no stones are found at operation. For the most part the ratio as shown by reports from different sources is fairly constant, stones being found in approximately 65 to 70 per cent of cases, while from 30 to 35 per cent are classified as cholecystitis without stones.

The hypothesis that cholecystitis is the real cause of the morbidities of gallbladder origin and that gallstones are only an incidental by-product has been comforting to many surgeons, but to me the problem of the stoneless gallbladder presenting no very clear-cut evidences of pathologic change has always remained an unsolved riddle. The literature on gallbladder surgery has not been particularly helpful because for the most part end-result reports have included only gallstone cases, or calculus and noncalculus cases have been grouped indiscriminately. In 1910, I sought to get some information for myself on this subject and ascertained the end results in ninety-nine cases in which operation was performed by Dr. A. J. Ochsner, Dr. McMullen and myself. The results of this study were not reassuring. Only forty-six of the ninety-nine patients were cured, and altogether the postoperative histories were such as to lead me [1] at that time to state, "In this series, operations for cholecystitis without stones have not shown better results than could probably have been secured by medical means, and unless better results are obtained in this class of cases in the future, surgeons should learn to avoid them."

Ninety-two of the ninety-nine cases studied in this series were cholecystostomies. About this time, Moynihan and others came forward with statements to the effect that cholecystectomy and only cholecystectomy would cure these patients. Since then, I have done cholecystectomies in almost all cases in which I have operated for so-called noncalculous cholecystitis. Nevertheless, experience soon showed that even with cholecystectomy the results in the stoneless gallbladder operations were often disappointing.

The study on which this paper is based was undertaken with the purpose of again checking my postoperative results in this class of cases. The results are apparently of some general interest in that they seem to indicate a rather clear-cut clinical line of demarcation between the patient destined to give a good postoperative end result, and the one destined to give a poor end result.

In 282 gallbladder operations that I performed previous to January, 1926, stones were present in 216, or 77 per cent, and absent in sixty-six, or 23 per cent. After reviewing the histories of these cases, I feel that the apparent, partial elimination of noncalculous cases has been the result of a rather conservative attitude toward gallbladder patients with histories showing the lesser grades of morbidities.

While it is relatively easy to get a correct perspective of the surgical end results in true gallstone cases, it is by no means a simple task to arrive at anything like a true perspective in the noncalculous cases.

The ordinary space basis method of tabulating end results is totally inadequate. This method consists in simply tabulating the patients as cured, improved or unimproved as they existed (in space) at the moment of the investigation, or at the time when their condition was last known. By this method even patients operated on under gross errors of diagnosis as, for instance, diaphragmatic pleurisy or acute pyelitis or what not, may all appear as cured at the time of the investigation.

Studied on a space basis, the forty-four cases in my series in which the condition was known more than one year after operation show thirty-one, or 71 per cent, cured or satisfactorily improved, and 13, or 29 per cent, with unsatisfactory results. These figures approximately correspond to those reported by other writers. However, a study of the individual histories shows that they include recoveries in cases of definitely known errors in diagnosis, and also cases in which the true recovery took place only months or years following the operation.

In the very nature of things, the group without gallstones must contain all cases in which operation was done under a mistaken diagnosis, and even though these patients recover from the operation and remain well thereafter, they must be segregated and considered by themselves. Viewed in the light of subsequent events and additional diagnostic data obtained since the date of operation, twelve patients operated on for gallbladder disease are now definitely known to have been operated on under a mistaken diagnosis. This is 18 per cent, or one in five, of the no stone cases; but as regards the total gallbladder operations, it represents only one known error in diagnosis in each twenty-three gallbladder operations.

In this group of known errors, there are four heart cases; two cases of acute pericarditis; one case of angina pectoris, and one case of paroxysmal tachycardia. In view of the great frequency with which cardiac disease may somewhat simulate gallbladder symptoms, and the fact that many true gallstone cases demand operation irrespective of coexisting heart trouble, it is interesting to find only one case of the angina type of heart trouble. Operation in the one case of paroxysmal tachycardia was based on a misleading history. The diagnosis was perfectly clear with the next attack of cardiac trouble.

The two heart cases that proved most confusing and embarrassing were two cases of acute pericarditis. I missed both of these diagnoses absolutely, although both patients subsequently had typical attacks of acute pericarditis with effusion.

Three patients after operation were found to be suffering from hysteria and not gallbladder disease. Until we develop some pathognomonic, hysteria-proof sign for gallbladder disease, the abdominal surgeon will probably continue to be fooled now and then by patients suffering from hysteria. The woman with hysteria and a fair knowledge of the symptomatology of gallbladder attacks is a dangerous diagnostic possibility.

Two patients, uncured by their gallbladder operations, subsequently developed cancer of the pancreas. The beginning, but not yet recognizable, cancers were probably responsible for the symptoms for which the gallbladders were operated on.

One patient had syphilis of the liver which was provisionally recognized at operation. She was promptly cured by antisyphilitic treatment. One patient was cured by treating a general abdominal ptosis. Another was subsequently relieved by cutting a dense band of

1. Stanton, E. M.: End Results in Gallbladder Surgery, J. A. M. A. 57: 441-444 (Aug. 5) 1911.

adhesions which caused intermittent partial intestinal obstruction.

When the known errors in diagnosis are eliminated, there is still a group of fifty-four cases, classed as cases of cholecystitis without stones.

In seventeen, the operations have either been of too recent date to determine the end result, or the patients were lost from observation soon after the operation. This leaves thirty-eight cases with end results known over periods of from one year to seventeen years after operation.

Twelve out of the thirty-eight were apparently definitely and permanently cured by their operations. Ten of these operations were cholecystectomies, and two cholecystostomies. Some of the results were as brilliant as any I have ever had in gallbladder surgery.

The case of Mrs. V., aged 73, operated on, July 29, 1913, is illustrative. She gave a history of gallbladder colics extending over a period of ten years, with three weeks before operation a particularly severe attack that had made her an invalid up to the time of operation. Operation revealed an acute empyema of the gallbladder without stones. Notwithstanding the evident infection present and the greatly thickened walls, plastered over with omentum, a simple cholecystostomy was done, and this woman, now aged 86, had, up to April 15, 1926, not had a symptom referable to the gallbladder since the operation thirteen years before.

In going over this group of highly satisfactory cases, I find the apparent pathologic changes to have varied from one gallbladder described as "apparently normal but removed because of the very definite clinical symptoms" to acute purulent cholecystitis. As a matter of fact, the conditions described fail to show any pathologic factors common to the group. One noteworthy fact is that the term "strawberry gallbladder" was not used in describing any case in this group.

As regards the symptomatology this group is, however, noteworthy in that ten out of the twelve histories record that the patients suffered from apparently typical gallbladder colics, and even the two patients whose attacks are recorded as not typical suffered from painful abdominal attacks which probably should have been described as gallbladder colics.

The foregoing observations, as to both the pathologic conditions and the symptomatology, are in accord with the recently reported results from the Mayo Clinic. In regard to the symptomatology, Judd [2] says of the noncalculous cases that if the patient had had attacks of severe, colicky pain he was almost sure to obtain relief by cholecystectomy, but the results of operating for indefinite symptoms were very unsatisfactory. This relationship between true gallbladder colics and good end results is apparently very definitely shown in my series.

The next group, containing fifteen cases, is made up of five cholecystostomies and ten cholecystectomies, all reporting cured or satisfactorily improved at the time of the last end-result note, but in none of these cases can I demonstrate a one to one cause and effect relationship between the operation and the final result. Either final recovery took place months or years after the operation, or there have been intervening recurrent attacks of symptoms indistinguishable from those for which the patient was operated on.

A typical example is the case of Miss K. B., a graduate nurse, aged 36, operated on, April 19, 1915. She was suffering from frequently recurring attacks of dull pain and pressure in the upper right abdomen accompanied by vomiting. During the attacks, she was afraid to eat. The nausea and distress were described as "terribly distressing," but the pain was hardly of the sharp, clean-cut type of true gallbladder colic. She had been an invalid as a result of the trouble for nearly a year. Operation disclosed some slight adhesions between the gallbladder and the omentum, and a mild grade of so-called strawberry gallbladder. A cholecystectomy was performed. The appendix had been removed at a previous operation performed elsewhere.

The knowledge that she no longer had a gallbladder proved a considerable comfort to her and to her family physician, and I was in a position to talk very encouragingly to her. Nevertheless, she continued to have the same old symptoms for several months, and then with gradually lessening frequency and intensity until the year 1921, six years after her operation. However, June 5, 1926, she told me that she had had no attacks for the last five years, had gained about 50 pounds (23 Kg.), and considered herself perfectly well except that fats and oily foods often caused considerable distress.

Histories like this as to sequences, but varying greatly as to time intervals, repeat themselves over and over again in this group. After cholecystectomy, the gallbladder is no longer a possible actor in the picture; otherwise, I can find no noteworthy difference between those who had cholecystostomies performed and those who had cholecystectomies.

The outstanding feature of the symptomatology of these cases is that in only three of the fifteen are the attacks described as "apparently typical" gallbladder colics. Again, this group suggests the thought that the moment gallbladder surgery is extended to include patients not suffering from typical, clinically recognizable attacks of gallbladder colic, we are treading on dangerous and unsatisfactory ground.

Ten patients, when last heard from, were still suffering from abdominal symptoms similar to those for which their operations were performed, and therefore are classified as unimproved. It is worthy to note that seven of the ten were traced only for about one year each after operation. Very probably, as in the preceding group, some of these patients have recovered at still later periods; but, even so, there is no reason for crediting the recovery to the operation. There were eight cholecystectomies and two cholecystostomies in this group. Nine out of the ten histories fail to record typical gallbladder colics. The one patient in whose history an apparently typical gallbladder colic is recorded was operated on soon after this first attack and remained well for four years after a simple cholecystostomy, since which time his painful attacks have recurred at rare intervals. In 1914, four years after his original operation, I seriously considered reoperation, but the condition cleared up at that time, and in 1925, when I last saw him, he felt that his discomforts did not warrant a second operation.

The pathologic changes recorded in the two groups of twenty-five patients not definitely benefited by operation are not very definite, nor, according to my present point of view, altogether convincing. Adhesions are definitely described in most cases. In several, the only demonstrable abnormality was the enlargement of the lymph node that lies alongside the cystic duct. Several were described as strawberry gallbladders. The term "strawberry" gallbladder is probably largely a mental conception, and therefore allows of much latitude in its application, depending on the individual surgeons or pathologists making the observations. Because I was never convinced of its pathologic nature, I have probably not recorded this condition as often as some other

2. Judd, E. S.: Clinical Versus Pathologic Cholecystitis, Collected Papers of the Mayo Foundation **17**: 155, 1925.

surgeons would had they described the same gallbladders.

CONCLUSIONS

1. All actual objective data that I have studied points to the conclusion that in the present state of our knowledge the one reliable indication of gallbladder disease of a type yielding to surgical intervention is the presence of well defined attacks of gallbladder colic. If the surgeon is definitely certain of his ground relative to the clinical history of biliary colic, he can proceed to remove the gallbladder irrespective of demonstrable gallbladder disease.

2. Just so far as the clinical picture of true biliary colics becomes doubtful, or the clinical picture shades over into ill defined digestive disturbances of the general type that many surgeons have been wont to call the symptoms of the precalculous stage of cholecystitis, do the end results of operative treatment begin to fail.

3. As in chronic appendicitis, it seems highly probable that the indications for operation must be based and justified almost wholly on the symptomatology, and that little or no reliance can be placed on the pathologist's report until such time as pathologists learn to recognize a pathologic condition corresponding to the symptomatology.

Medical Arts Building.

Clinical Notes, Suggestions and New Instruments

CHRONIC BILATERAL PLEURAL EFFUSION AND MEDIASTINITIS *

WILL HOWARD SWAN, M.D., AND LEO WILLIAMS BORTREE, M.D., COLORADO SPRINGS

Bilateral pleural effusion, while a common incident in circulatory failure and an occasional concomitant of pulmonary tuberculosis, is a rare condition in chronic mediastinitis. It is on this account that we are reporting this case of chronic mediastinitis and bilateral pleural effusion of inflammatory origin, type not determined.

A fairly exhaustive search of the literature has not disclosed a similar case on record. Cases of mediastinitis which have shown effusions have usually produced only small collections of fluid located largely in the posterior mediastinum or in the interlobar fissures.

REPORT OF CASE

A married woman, aged 35, referred to us by Dr. Walter Baumgarten of St. Louis, gave a negative family and personal history, stating that she had always been well up to February, 1922, when she developed an acute respiratory infection which was diagnosed as influenza. This began in the nose and was followed by soreness in the chest, cough, expectoration, nasal discharge and general weakness. She was first seen by Dr. Baumgarten in November, 1922, at which time he made a diagnosis of bilateral pleuritic effusion, inflammatory in character, general sinus infection, tracheitis and possibly bronchitis. In addition to aspirations of both pleural cavities, he had the antrums and frontal sinuses operated on. In spite of this treatment, she remained in virtually the same condition until the time she came under our care in August, 1923.

The patient was well nourished and did not appear very ill. The nose showed chronic maxillary and frontal sinusitis. All the teeth were artificial. The heart was normal in all respects, as was the abdomen except for an indistinctly palpable and slightly tender liver. The thumb nails and all toe nails were rough and yellow on the distal two thirds, but smooth and normal in color on the proximal third. The chest was symmetrical, with equal expansion on the two sides, lessened in degree and largely diaphragmatic.

On the right side there was flatness below the fourth rib and seventh dorsal spine, dulness below the second rib and fifth dorsal spine, and normal resonance above that level. Breath sounds were absent in the flat area and feeble in the dull area. There were a few indistinct indeterminate râles in the second and third interspaces near the sternum.

The left side was flat below the fourth rib and seventh dorsal spine, with normal resonance above. There was absence of breath sounds over the flat area, with normal breathing above. No râles were elicited.

Roentgenograms of the chest showed extensive bilateral pleural effusion, but no indications of tuberculous lesion. Roentgenograms of the head showed clouding of the frontal and maxillary sinuses.

The sputum on repeated (fourteen times) examination and with guinea-pig inoculation failed to show tubercle bacilli. The urine was negative except for a trace of albumin and an occasional hyaline cast. A guinea-pig injected with a specimen showed no evidence of tuberculosis. The blood Wassermann reaction was negative. The pleural fluid was clear, and straw colored, with a specific gravity varying between 1.018 and 1.022; albumin was present in large quantities, and the cell count varied from 300 to 6,000 per cubic millimeter. It was usually below 700, the higher figures resulting after the injection of gentian violet solution. A differential count of the cells gave an average of 90 per cent lymphocytes and 10 per cent polymorphonuclears. Cultures were always sterile, and no tubercle bacilli were found either on stained smears (ten times) or following animal inoculation. Very few blood cells were seen, and usually their presence could be ascribed to trauma.

During the time that this patient was under the care of Dr. Baumgarten he found it necessary to aspirate each of the pleural cavities nine times in a period of nine months in order to relieve the dyspnea, which was the presenting symptom. From the right chest he took a total of 16,600 cc. of fluid and from the left, 11,220 cc. in the nine aspirations. In each case the character of the fluid withdrawn was as outlined above.

While the patient was under our care, the clinical course remained the same. At first the aspirations gave relief from the dyspnea, but, during the last months of her illness, the withdrawal of the fluid failed entirely to relieve this very distressing symptom. Toward the end it was necessary to aspirate the right chest every three or four days. The left pleural cavity became obliterated, and little fluid could be obtained from it the last four weeks of life.

From the date of her arrival, Aug. 21, 1923, to her death, May 23, 1924, we aspirated the right chest forty-eight times, withdrawing a total of 49,985 cc. of fluid, and the left thirty times, aspirating a total of 23,010 cc. This makes a grand total of fifty-seven aspirations of the right chest and a withdrawal of 66,585 cc. The left chest was tapped thirty-nine times, obtaining 34,230 cc. From the pleural cavities of this patient there was taken a total quantity of 100,815 cc. of exudate during the period from Nov. 21, 1922, to May 21, 1924, an interval of eighteen months.

During our period of observation, the temperature range was usually from 98 to 99, rarely reaching 100. The pulse rate ranged from 74 to 110, the higher rate appearing usually just before aspiration was needed. The respiratory rate varied widely, being rapid when the pleural cavities were filled with fluid, but dropping to normal limits following aspiration, especially during the earlier part of the illness. During the latter part of the patient's life, it became increasingly difficult to withdraw all the fluid from the right pleura. The needle would become blocked while the physical signs indicated that much fluid yet remained. Sometimes a slight movement of the needle sufficed to relieve the block; at other times it required a reinsertion in another spot to obtain fluid. The necropsy report indicates the reason for this difficulty.

The treatment used consisted, in addition to the usual sanatorium regimen, of irrigation and suction to drain the infected sinuses, aspiration as needed to relieve the dyspnea, and the injection of 2 per cent solution of formaldehyde in glycerin after aspiration of fluid; a similar use of 1:1,000 aqueous solution of gentian violet, and the injection of some of the aspirated fluid into the patient's own tissues. The quartz lamp was used for a time. Sedatives were frequently required, and

* Read at the forty-third annual meeting of the American Climatological and Clinical Association, Philadelphia, Sept. 27, 1926.

symptomatic therapy was instituted as indicated. There was no response to any form of treatment in the way of a betterment of the condition. The only ill effect seen was following the use of the gentian violet solution, when the patient had a rather marked rise of temperature, with rapid pulse and pleural pain. The fluid withdrawn following this was not only colored by the dye for ten days, but also had a high cell count (6,000 per cubic millimeter) with a high percentage of polymorphonuclears (70 per cent). The cell count subsided to the former limits and characteristics as the dye faded from the exudate. The use of formaldehyde did not provoke any untoward reaction. Neither solution had any effect in reducing the formation of the fluid.

The patient died suddenly, May 23, 1924, two years and three months after the onset of the illness, and eighteen months after the fluid was first found to be present. It was with extreme difficulty that permission for necropsy was obtained, and the time allowed was so brief that it was impossible to perform as complete an examination as was desired. However, it was possible to obtain the following data: The liver was displaced entirely below the costal border by the fluid in the right chest. On its free edge was a nodule, afterward proved to be aberrant suprarenal substance. The appendix was slightly enlarged and showed a few adhesions near the tip. The heart, pericardium and kidneys were normal. The head and extremities were not examined.

In the right chest the pleural cavity was divided into several compartments by thick membranes of gelatinous substance. All these compartments were filled with straw colored fluid. The quantity was not measured, but probably there were several liters. There was one dense adhesion to the lateral wall at the level of the fourth rib in the axillary line. The lung was densely adherent to the mediastinum and the dorsal chest wall. The lower lobe was atalectatic; the balance appeared normal. There were no tubercles found and there was no enlargement of the bronchial glands. The lung itself appeared normal.

In the left chest the pleurae were adherent throughout, and there was practically no fluid present except a small collection in the interlobar space, which had been enclosed by adhesions. In order to remove the lung, it was necessary to take the parietal pleura with the visceral. The pleura was much thickened and the adhesions were of the same gelatinous character as on the right. Evidence of tuberculosis was not present in the lung, and the bronchial glands were not enlarged. A part of the lower lobe showed gray hepatization, but the remainder of the lung was free from pathologic changes.

Around the lower end of the esophagus in the lower part of the mediastinum was some fat tissue and a collection of the same gelatinous substance as was found in the pleurae. In the upper mediastinum, surrounding the arch of the aorta, was a marked infiltration of fat tissue and gelatinous substance. There was here found a black lymphatic gland about 1 cm. in diameter embedded in the gelatinous substance.

Microscopic examination of the tissue found in the mediastinum showed connective tissue covered by a massive layer of fat which was very vascular and contained edematous areas of loose connective tissue showing slight chronic inflammatory infiltration. The fat tissue contained a high percentage of distinctly small cells, the type of which was not stated.

The pleura was much thickened and vascular with fairly marked chronic inflammatory infiltration, and a thick layer of edematous fibrin containing blood and a few leukocytes. There were no fatty areas seen. The underlying lung showed a partial compression of the alveoli, many of which were choked with cells, including large round phagocytic cells, lymphocytes and cells of plasma type. There were hardly any polymorphonuclears. There was a large accumulation of lymphocytes just beneath the pleura, and some desquamation of the bronchial epithelium. Tubercles were not seen. Cultures were not possible, as the body had been embalmed.

The pathologic diagnosis rested between (1) chronic infectious inflammation of the mediastinum and pleurae of unfamiliar type with secondary deposition of fat, and (2) diffuse lipoma of the mediastinum with secondary changes in pleurae and lung due to circulatory interference.

Shortly after this report was rendered, we were fortunate in being able to submit the case report and the microscopic sections to Professor Aschoff of Freiburg for his opinion. After studying the sections and reading the history, he made a diagnosis of chronic nontuberculous pleuritis and mediastinitis of unknown cause, probably a direct result of influenza.

SUMMARY

This is a case of bilateral pleural effusion of clear, sterile fluid over a period of at least eighteen months due to chronic nontuberculous mediastinitis and pleuritis. There were no heart or kidney changes associated with the lesion. Almost 101 liters of fluid was withdrawn during the illness. The antecedent cause appears to have been influenza.

312 Ferguson Building.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION.

W. A. PUCKNER, SECRETARY.

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE (See New and Nonofficial Remedies, 1926, p. 333).

Cutter Laboratory, Berkeley, Calif.

Diphtheria Toxin-Antitoxin Mixture, 0.1 L+.—Each cubic centimeter of the mixture represents 0.1 L+ dose of diphtheria toxin neutralized with the required amount of antitoxin. Marketed in packages of three 1 cc. vials, representing one complete immunization; in packages of thirty 1 cc. vials, representing ten complete immunizations; in packages of one vial containing 50 cc.

TUBERCULIN-KOCH (See New and Nonofficial Remedies, 1926, p. 344).

Eli Lilly & Company, Indianapolis.

Pirquet Test.—Old tuberculin marketed in packages of three capillary tubes, each tube containing sufficient material for one test.

Tuberculin Ointment for the Moro Percutaneous Test.—Marketed in collapsible tubes containing 2 Gm. of an ointment consisting of equal parts of tuberculin "Old" and wool fat.

Old Tuberculin, Human Strain, Concentrated.—Marketed in 1 cc. vials for making dilutions for therapeutic use or for making the subcutaneous diagnostic test. Each cubic centimeter equals 1 Gm. of tuberculin.

NEW TUBERCULIN T. R. (See New and Nonofficial Remedies, 1926, p. 347).

Eli Lilly & Company, Indianapolis.

Tuberculin, T. R. Concentrated, Human Strain.—Marketed in single 1 cc. vial packages containing 2 mg. of solids per cubic centimeter.

NEW TUBERCULIN B. E. (See New and Nonofficial Remedies, 1926, p. 347).

Eli Lilly & Company, Indianapolis.

Tuberculin, B. E. Concentrated, Human Strain.—Marketed in single 1 cc. vial packages containing 5 mg. of dried tubercle bacilli per cubic centimeter.

TUBERCULIN DENYS (See New and Nonofficial Remedies, 1926, p. 349).

Eli Lilly & Company, Indianapolis.

Tuberculin, B. F. Concentrated, Human Strain.—Marketed in single 1 cc. vial packages.

PLAGUE BACILLUS VACCINE (See New and Nonofficial Remedies, 1926, p. 354).

Eli Lilly & Company, Indianapolis.

Plague Vaccine, Prophylactic.—Marketed (for single vaccinations) in packages of two 1 cc. vials containing, respectively, 1,000 and 2,000 million killed plague bacilli per cubic centimeter; in packages of ten 1.5 cc. vials containing 2,000 million killed plague bacilli per cubic centimeter; in packages (for double vaccinations) of one 20 cc. vial containing 5,000 million killed plague bacilli per cubic centimeter; in packages of three 1 cc. vials containing 5,000 million killed plague bacilli per cubic centimeter.

CHOLERA VACCINE (See New and Nonofficial Remedies, 1926, p. 351).

Eli Lilly & Company, Indianapolis.

Cholera Vaccine, Prophylactic.—Marketed in packages of three 1 cc. vials, one containing 500 million killed cholera vibrios per cubic centimeter, and the second and third each containing 1,000 million killed cholera vibrios per cubic centimeter; in packages of ten 2.5 cc. vials each containing 1,000 million killed cholera vibrios per cubic centimeter.

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SATURDAY, DECEMBER 25, 1926

THE PHYSIOLOGIC AVAILABILITY OF IRON

The function of iron in the body is usually discussed from the point of view of its relation to the blood. Not by any means, however, does this aspect of the element represent its whole importance. Sherman[1] has expressed the situation broadly in the statement that iron stands in the closest possible relation to the fundamental processes of nutrition, as an essential element both of the oxygen-carrying hemoglobin of the blood and of the chromatin substances that appear to control (in some degree at least) the most important and "vital" activities within the cells. Recent work indicates also that small amounts of iron in other forms may play an important part in catalyzing the oxidation-reduction reactions through which the potential energy of the oxidizable foodstuffs is made kinetic for the support of the work of the active tissues of the body. The fact that the amount of iron in the body is small—rather less than 3 Gm., hardly a tenth of an ounce in the entire body of a healthy full-grown person, about 0.004 per cent, or 1 part in 25,000 by weight—indicates that there cannot often be great demand for the element from a quantitative standpoint. This circumstance, particularly in view of the widespread distribution of iron in natural foods, has given emphasis to the belief that it is the type of the iron compounds available rather than primarily their quantity that determines their physiologic usefulness.

The study of the availability of iron compounds for hemoglobin formation has been conducted both by clinical observation and by animal experimentation. In the latter case it has been customary to observe the response to administration of the products under consideration after depletion of the blood pigment through hemorrhage. The conflicting views have already been reviewed in THE JOURNAL.[2] The conditions represented by such secondary anemias are not necessarily identical with the more common conditions of actual iron shortage. Consequently, interest centers in recent experiments by Mitchell and Schmidt[3] of Battle Creek in which the relief of a true nutritional anemia was attempted. They, too, showed the availability of iron from both organic and inorganic sources. Some of the popular beliefs and traditions that are promoted in various ways have been tested. It is made clear that spinach and raisins are not the only recourse for iron help in times of anemic stress. Meat and molasses lead in a superior category. In connection with the use of inorganic iron, the observations suggest that a new line of differentiation be drawn as regards the availability of iron in the animal organism; namely, soluble versus insoluble rather than merely organic versus inorganic.

The belief that the green plant pigment chlorophyl has a particular significance in influencing the availability of iron is not borne out by the experiments of Mitchell and Schmidt, though these do not necessarily give the last word on the subject. Biochemists will still adhere to the possibility that pigment-forming radicals are as essential to hemoglobin formation as are iron and protein, and that they are derived chiefly from chlorophyl and related coloring matters, such as those of green and yellow vegetables, egg yolk and milk fat. That feature of the formation of hemoglobin—the production of what has lately been termed "haem" or "hem" to designate the nonprotein part of hemoglobin, containing pyrrole-nuclei and iron—deserves more extensive investigation before the hypothesis is finally abandoned.

1. Sherman, H. C.: Chemistry of Food and Nutrition, ed. 3, New York, Macmillan Company, 1926.
2. Iron in Therapeutics, editorial, J. A. M. A. **85**: 1140 (Oct. 10) 1925; Iron and Blood Regeneration, ibid. **86**: 1075 (April 3) 1926.
3. Mitchell, Helen S., and Schmidt, Lola: The Relation of Iron from Various Sources to Nutritional Anemia, J. Biol. Chem. **70**: 471 (Oct.) 1926.

THE TREATMENT OF NEUROSYPHILIS BY MALARIA

The treatment of neurosyphilis by fever-producing methods, notably by the genesis of malaria in the patients, cannot longer be classed as a novelty. The cases under observation are already numbered by the hundreds, so that it becomes desirable to take account of the outcome from time to time. The problem under consideration is complicated by the admitted fact that spontaneous remissions of the principal symptoms are known to occur, so that some improvement may be expected under practically all forms of treatment. Nothing less than the statistics of a large number of patients in observations extending over periods of time that are measured by years rather than months will justify anything more than tentative conclusions. Nevertheless, the discussion[4] at the golden anniversary meeting of the American Dermatological Association in Philadelphia a few months ago gives encouraging indications of the value of the von Jauregg method in the treatment of parenchymatous neurosyphilis, particularly of the general paralytic type. It also suggests that some of the complications of neuro-

4. O'Leary, P. A.; Goeckerman, W. H., and Parker, S. T.: Treatment of Neurosyphilis by Malaria, Arch. Dermat. & Syph. **14**: 550 (Nov.) 1926.

syphilis, such as gastric crises, persistent lightning pains and optic atrophy, will be ameliorated by fever therapy. The reports from abroad are likewise promising and their favorable character seems to increase as the number of patients under observation grows.

The malarial therapy of neurosyphilis has limitations that need to be appreciated at the outset. Treatment of such a drastic nature must be carried out under the best conditions for observation and management. There are obvious "poor risks"; the responses are apparently not equally advantageous in all types of syphilitic disease of the nervous system. In evaluating the outcome, patients with general paralysis must perhaps be segregated from those exhibiting other forms of neurosyphilis.

It is also essential not to expect the unattainable. Certain portions of the nervous system that have undergone degeneration will not be restored or rejuvenated by any form of treatment. Remissions must be judged by a physiologically attainable standard. O'Leary [5] has insisted that any method of treatment has a definite place in the armamentarium of the syphilologist if it maintains or restores the earning capacity of the patient with general paralysis; if, being unable to resume his former occupation, which was of a mental type, the patient with general paralysis is able to provide for himself and his family by more menial work, or if the treatment has produced a greater number of remissions than would have occurred spontaneously.

The most critical syphilologists now base their interpretation of what constitutes a successful form of treatment for general paralysis on the amelioration or disappearance of the symptomatic complaint and not on the objective signs. O'Leary adds that until years of continued observation with opportunities for study of microscopic changes in similar groups of cases impress us with the ability of malaria therapy to restore injured tissue in general paralysis, we should endeavor to maintain the same criteria in estimating the value of fever therapy. The current impressions have been well summarized by Schamberg, who admits that although the time has not yet arrived to evaluate accurately the malarial treatment of syphilis and discount the enthusiasm that is commonly engendered by new treatments, malarial inoculation has accomplished results in syphilis of the nervous system not heretofore achieved by other methods. Recently attention was called in these columns [6] to new substitutes for the malarial treatment of neurosyphilis. One of these provides the use of the micro-organism of rat-bite fever, or sodoku, to produce the febrile paroxysms; the other involves the production of febrile reactions by protein injections, without the use of any living organisms. The latter has yet to prove its worth, though the immense importance of success thereby makes desirable a thorough study of the technic, which has not yet been described adequately.[7] The question at issue involves the possible necessity of having living plasmodia or other organisms present to secure successful therapeutic reactions. In any event, it is of interest to learn from various competent observers that, in countries and localities where malaria is widely prevalent, syphilis of the central nervous system seems to be a comparatively rare disease.

5. O'Leary, P. A., and Becker, S. W.: Further Observations on the Treatment of Neurosyphilis with Tryparsamide, M. J. & Record **123**: 305 (March 3) 1926.

6. The Treatment of General Paralysis by Fever-Producing Methods, editorial, J. A. M. A. **87**: 1394 (Oct. 23) 1926.

7. Kunde, M. M.; Hall, G. W., and Gerty, F. J.: Nonspecific Protein Therapy in General Paralysis, J. A. M. A. **87**: 1376 (Oct. 23) 1926.

8. Von Müller, Friedrich: Observations During the Period of Undernutrition in Germany, Bull. New York Acad. Med. **2**: 502 (Oct.-Nov.) 1926.

SOME LESSONS OF WAR-TIME UNDERNUTRITION

The World War was responsible for many experiences that have thrown new light on problems of medical interest. There were surgical complications of a new sort demanding special recognition. Opportunity was afforded to study the comparative immunity of great numbers of persons who had received preventive treatment against certain infections, notably smallpox, typhoid and tetanus. Poisoning with war gases presented a distressing novelty never previously encountered in battlefield emergencies. Insect-borne diseases secured new inroads into previously unaffected masses of men. Such were the unusual experiences of combat. But among the noncombatants far from the firing lines the exigencies of the unexpected situations produced not a few consequences of physiologic moment, some of which were recently reviewed in an address before the New York Academy of Medicine by Professor von Müller [8] of Munich, who has lately been a widely welcomed visitor in the United States. Like other European observers of changes credited to war-time nutritional conditions, he noted that the enormous restrictions in the use of meats brought about a disappearance of gout; in fully developed cases of gout the affected joints showed distinct improvement. Among the population in general, the amount of uric acid in urine and blood fell to half of the normal level, not lower. It reached the level of the endogenous uric acid. This circumstance has led Müller to point out that, even on restricted diets that are essentially purine-free, the body is able to build up the complex nucleoproteins while it is absolutely unable to destroy uric acid. Not all of the chemical reactions in the body, he remarks, are reversible. The war demonstrated the significance of "rich food and alcoholic drinks" in the development of gouty conditions —not necessarily, however, the origin of the so-called gouty constitution.

The lowered basal metabolism that has repeatedly been shown by experiment to follow prolonged undernutrition was manifested on a large scale in

the underfed civilian war-time population of central Europe. There is a lesson here to those propagandists who champion drastic food reduction as a universal measure. In consequence of enforced undernutrition in Europe there was, as Müller reports, a reduction of body temperature, pulse rate and blood pressure and the vitality of certain organs with a resulting diminution of mental and bodily efficiency and a diminished resistance against disease. Tuberculosis ran a more malignant course and a frightfully increased mortality—from about 50 to 90 per cent. Pneumonia and other infectious diseases and surgical operations showed a diminished tendency toward recovery. During the early part of the war, some optimistic physicians had published the opinion that the German people had been overfed and that a reduction of food was not only allowable but also beneficial. But when the real diminution in food took place it became clear that it was not a benefit but a menace.

The frequently discussed hunger edema seemed to follow bad harvests and disappear when more abundant food supplies became available. Potatoes, in particular, saved the German population from starvation. Müller does not rate such edema as an avitaminosis, nor does he regard the diminution of fertility a characteristic and pathognomonic sign of it. Even in severe cases of hunger edema, no real anemia was present; chlorosis was not common. It may be concluded, therefore, that even during a time of serious lack of food the synthesis of the complicated hemoglobin molecule takes place without difficulty. It is fortunate, indeed, that some of the most essential constituents of the organism can apparently be synthesized in the body. This is in advantageous contrast to the indispensability of exogenous sources of vitamins and certain inorganic nutrients.

Current Comment

"VEGETABLE PURINES" AND URIC ACID

The system of living which teaches that the food of man should be derived directly from the plant world has usually involved something more than a mere dietetic program. Vegetarianism has often been advocated with the allegation that the use of foods of animal origin is morally wrong as well as erroneous with respect to the processes of nutrition. From the physiologic standpoint the arguments have involved certain menaces supposed to be characteristic of the animal products; thus, the latter have been pointed to as sources of purine derivatives, the precursors of the much discussed uric acid. The accusation is warranted; ingestion of meats and in particular glandular organs such as the liver and kidneys gives rise to an augmented output of uric acid. If for any reason the use of a purine-free regimen is called for, such animal products must either be excluded or consumed in restricted amounts. The implication, however, that foods of plant origin are necessarily purine-free and therefore do not contribute to the production of uric acid in the human dietary is by no means warranted. If a demonstration were needed, it would be afforded by the metabolism investigations of Wheeler and Wallace[1] at the State University of Iowa. Diets estimated to furnish about 1.5 Gm. of purines were selected in periods alternately from vegetable foods and from animal products, notably meat. For the former, peas, beans, onions, asparagus and certain cereals supplied the investigated precursors. The outcome was unequivocal: vegetable purine caused an increase in the blood uric acid equal to that of a similar quantity of meat purine. Excretion of uric acid was increased by vegetable purines as well as by meat purines. This is in harmony with the long known occasional occurrence of "cereal gout" in persons not accustomed to a meat-containing dietary. There is no convincing physiologic reason for recommending an exclusive diet of either animal or vegetable origin as a universal panacea.

DOES NORMAL URINE CONTAIN GLUCOSE?

When the urine of supposedly healthy persons is carefully examined by one of the delicate reduction tests to which sugars respond in small quantities, a reaction is usually obtained. This has often given rise to the statement that normal urine always contains some carbohydrate. As substances other than sugar, notably uric acid and creatinine, both of which occur in urine, may initiate a similar reduction reaction, the phenomenon is by no means an unmistakable indication of the presence of sugar. However, various biochemists have succeeded in isolating products that are unmistakably carbohydrate in character from large quantities of specially treated and concentrated normal urine. Part of these are admittedly unfermentable; but another part has been asserted to be fermentable and identical with the blood sugar glucose. The determination of the actual physiologic condition is of more than academic interest. As Greenwald, Gross and Samet[2] have pointed out, if it could be definitely established that glucose is not present in human urine under anything like normal conditions, the development of a delicate, specific reaction for glucose should be of considerable value in the detection of diabetes. If, however, glucose is normally present in the urine, the development of a technic for the detection of early or slight deficiencies in carbohydrate tolerance must take a decidedly different course. According to these investigators, the sugars excreted in normal urine are made up of carbohydrates assimilable with difficulty or not at all, and of reducing substances derived from the protein of the food and from endogenous sources. The nature of those in the former group depends on the diet. This group may include lactose from milk, pentoses from fruits, and caramelized sugars and dextrins. The amounts of all of these are usually small. Glucose was missed in all cases in which the intake of this sugar was not unduly

1. Wheeler, Ruth; and Wallace, Bessie I.: The Effect of Vegetable Purines on the Blood in Gout, J. Am. Dietetic A. 2:52 (June) 1926.

2. Greenwald, I.; Gross, J., and Samet, J.: The Nature of the Sugar in Normal Urine: II. The Sugar Excretion upon Various Diets and the Influence of Diet upon Glucose Tolerance, with Some Remarks on the Nature of the Action of Insulin, J. Biol. Chem. 63:401 (Dec.) 1924.

large. Subsequent studies of Höst,[3] and of Lund and Wolf,[4] also have pointed to the absence of glucose from normal urine. Investigation by Patterson[5] at the Charing Cross Hospital Medical School in London is also confirmatory. He found that under conditions in which glucose is readily fermentable, the "sugar" of normal urine is completely unfermentable. These facts seem to establish the complete impermeability of the kidneys to the blood sugar under the normal conditions of health and diet. They also lend a renewed interest to the identity and significance of the carbohydrates that actually do escape through the renal barrier.

3. Höst, H. F.: J. Metab. Research **4**: 315, 1923.
4. Lund, G. S., and Wolf, C. G. L.: The Glucose Content of Normal Urine, Biochem. J. **19**: 538, 1925.
5. Patterson, J.: The Carbohydrate of Normal Urine, Biochem. J. **20**: 651, 1926.

Fundamental Principles of Medical Practice.—In the sphere of everyday medicine, especially in that conducted by general practitioners, the competition of amateur doctors and numerous cults or stunts has always played and, unless human nature alters in an unexampled manner, always will take a prominent part, which must be accepted in a philosophic spirit. A fundamental principle of preventive medicine is education of the public in personal hygiene, and this may lead to the acquisition of that small amount of knowledge which is proverbially dangerous, and may encourage treatment not only of self but of dependents and friends. As many persons, acting on the assumption that forty years of life make an individual either a physician or a fool, are convinced that they are as good as, or better than, doctors, a considerable amount of rather irresponsible treatment—in other words, a more advanced grade of domestic medicine—is likely to result. It must be remembered that such lay medicine is largely the outcome of past medical opinion or advice, and so up to a certain point is often sound. From such domestic medical practice it is but a step to an addiction to patent proprietary potions and pills, with which, as proved by their widespread advertisements, so many people dose themselves and others so freely and sometimes not too wisely.—Rolleston, Humphry: *Brit. M. J.* **2**:626 (Oct. 9) 1926.

Association News

THE WASHINGTON SESSION

Special Exhibit by the Section on Urology, with the American Social Hygiene Association Cooperating

The Committee on Section Exhibit appointed by the Section on Urology, in cooperation with the American Social Hygiene Association, announces that the plan is to limit the demonstration to gonorrhea in the male, taking up in an orderly manner the diagnosis—from a laboratory and clinical standpoint—of anterior and posterior urethritis, and generally accepted methods of treatment, diathermy and the criteria of cure. It is also planned that a comprehensive and valuable collection of material be shown, depicting the complications arising in the course of an attack of gonorrhea and the manner in which these complications are best treated. In the display of material, it is desired that the exhibitors limit their presentations to the fundamental and essential points. It is the earnest wish of the committee that the exhibit be a correlated one rather than a large one.

Circular letters explaining the exhibit together with application blanks will be mailed to those who registered in the Section on Urology at any of the last three sessions. Any who desire this literature may obtain it by communicating with the secretary, Dr. Walter M. Brunet, 370 Seventh Avenue, New York. All applications for this special exhibit must be sent to Dr. Brunet by February 15.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

CALIFORNIA

Personal.—Dr. Orin J. Riddell, Jr., has been appointed in charge of the laboratory and roentgen-ray departments at the Alhambra Hospital, Alhambra.——L. D. Inskeep, San Francisco, has been appointed health officer of Jackson County, Ore., to succeed Dr. Verne S. Gearey, who resigned to accept a fellowship at the Mayo Foundation, Rochester, Minn.

Illegal Practitioner Fined.—Abraham W. Lair, 1876 West Avenue, Los Angeles, recently paid a fine of $200 in Judge Richardson's court, following a plea of guilty to practicing medicine without a license, it is reported. Lair, according to testimony of Special Agent Albert Carter, state board of medical examiners, has been practicing medicine by his own admission for many years.

Society News.—Dr. Howard C. Naffziger addressed the Sacramento Society for Medical Improvement, recently, on "Treatment of Severe Head Injury"; the entire state board of medical examiners attended the meeting.——Dr. Charles C. Dickinson, McCloud, addressed the Siskiyou County Medical Society, Yreka, November 16, on "Rheumatic Arthritis."——On his recent tour, Dr. Edouard Rist, Paris, France, came to California as the guest of the California Tuberculosis Association; special meetings were held in Oakland, San Francisco and Los Angeles.

DELAWARE

Conclusions in Study of Automobile Accidents.—A committee of the Delaware State Conference on Street and Highway Safety made a statistical study of automobile accidents that occurred in the state over a period of several years. After consideration of the limitations of such studies, the conference concluded that in Delaware outside of the city of Wilmington (1) there has been a large increase in the number of automobile deaths in 1926 as compared with previous years; (2) while one half of the accidents occur in daylight and three fourths occur on dry pavements, the probability of the occurrence of accidents per unit of mileage traveled is comparatively very high in darkness and on wet pavements; (3) half of the automobile deaths are due to collisions between two automobiles, one fourth are due to collisions between automobiles and railroad trains, and only one fifth are the result of pedestrian carelessness; (4) automobile accidents are mainly due to the recklessness, carelessness and inattention of motorists. It was found in the city of Wilmington that three fifths of the persons killed were pedestrians; that one third of them were school children, and that women are more careful than men either as drivers or as pedestrians. The study was based on tables prepared by the state department of health, and the various hospitals of Wilmington cooperated.

ILLINOIS

Society News.—Dr. Frank C. Sibley, Carmi, has been elected president of the Southern Illinois Medical Association, and Dr. William J. Benner, Anna, secretary-treasurer; the next annual meeting will be at Murphysboro.——Dr. William Allen Pusey addressed the Medical-Historical Club at the University of Illinois College of Medicine, December 15, on "Some Great Doctors of the Backwoods."——Dr. Joseph C. Bloodgood, Baltimore, will speak at a public meeting under the auspices of the St. Clair County Medical Society at East St. Louis, January 7, 8 p. m., on "Cancer Control."—Dr. Jonas Curtis Lyter, St. Louis, will address the Waterloo Medical Society, Waterloo, January 19, on "Some Aspects of Cardiovascular Mechanisms in Chronic Pulmonary Emphysema."——Drs. Fred H. Gunn and Michael Earl Brennan, both of East St. Louis, addressed the Jackson County Medical Society, December 14, on "Peculiar Phases of Appendicitis" and "Lead Poisoning," respectively.

Chicago

Dr. Pollock Appointed Professor of Psychiatry.—Dr. Lewis J. Pollock, Chicago, has been appointed professor of neurology and psychiatry and head of the department at Northwestern University Medical School.

University News.—Dr. James B. Herrick retired recently as clinical professor and chairman of the department of medicine, Rush Medical College, and was appointed professor emeritus.——Dr. Harry A. Singer recently resigned as clinical associate in the department of medicine, Rush Medical College.——Dr. Herman N. Bundesen, city commissioner of health, was appointed professorial lecturer on public health administration in the department of hygiene and bacteriology at the University of Chicago for one year from October 1. ——Dr. Franklin C. McLean was appointed vice chairman of the faculty of the Graduate School of Medicine and of the Ogden Graduate School of Science for one year from July 1. ——Dr. Ernst Pribram was appointed assistant professor in the department of pathology, Rush Medical College, for one year from October 1.——Dr. Chester S. Keefer has been appointed resident physician in the Medical Clinic of the Billings Hospital, and instructor in medicine for two years from September 1.——Dr. Thomas D. Allen has been appointed to a traveling fellowship in Rush Medical College for six months from September 1.——Dr. Alice McNeal has been appointed anesthetist in the department of surgery, Rush Medical College, for four years from July 1.

INDIANA

Personal.—Dr. Paul F. Robinson has been reelected coroner of Marion County.——It is reported that Dr. Chauncey W. Dowden has resigned as head of the West Baden Springs Hospital and will return to Louisville, Ky., to practice.—— A. A. Wilson, formerly of South Dakota and New York, has been appointed on the staff of the child hygiene division of the state board of health.——Dr. William T. Gott, Crawfordsville, has resigned as secretary of the state board of medical registration and examination after twenty-seven years of service in that position; he will continue to serve as a member of the board.

Admissions to Riley Hospital.—A total of 4,272 children of Indiana were admitted to the James Whitcomb Riley Hospital, Indianapolis, or cared for at the clinics in the two years ending November 19. Patients are admitted to the hospital on commitment by judges of the courts of the county in which they live. The law provides that any child under 16 years of age may be committed if the judge considers the child has a disease or deformity which might be improved or cured in the hospital, and if the parent or guardian is not able to pay the expense of such treatment. The cost is borne by the county from which the children come on a day rate basis, the expenses being proportional to the amount each county makes use of the hospital. The professional medical service is provided, free of charge, by the staff of the state university school of medicine.

IOWA

Personal.—Dr. Alice M. H. Hatch has been elected president of the Medical Women's Club of Des Moines for the ensuing year, and Dr. Sophie Hinze Scott, secretary.—— Dr. Arthur R. Abel has been appointed pathologist to the Methodist and Lutheran hospitals, Sioux City.

Warning About Tularemia.—Six cases of tularemia were identified during November and December, with the assistance of the state laboratory service. The state epidemiologist has been informed that in some sections of the state many rabbits have been found dead. A warning has been sent to physicians to be on the lookout for tularemia among their patients. The state laboratories request specimens of blood from suspected cases and from rabbits that have died. The tularemia cases discovered in Iowa last year were in Johnson County; cases have been identified this year in Clay, Scott and Monroe counties. From 3 to 5 cc. of the patient's blood should be forwarded in suspected human cases, and a brief history of the case.

LOUISIANA

Physicians Indicted for Liquor Violation.—A federal grand jury at Lake Charles is reported to have indicted Drs. Alvan H. Lafargue and David S. Perkins of Sulphur, and Dr. Charles F. Howell of De Quincy on charges of violating the federal prohibition laws. The judge fixed the defendants' bonds at $2,000 each.

Society News.—Dr. P. H. Jones, among others, addressed the Orleans Parish Medical Society, New Orleans, recently, on "The Use of Lipiodol in the Bronchi," and Dr. Charles A. Bahn on "Swimming Tank Conjunctivis."——The Orleans Parish Medical Society, New Orleans, has elected Dr. Albert E. Fossier, president; Drs. John F. Dicks, Christian G. Cole and Edward L. King, vice presidents; Dr. John A. Lanford, treasurer, and Dr. Henry Theodore Simon, secretary. The guest of honor at the annual banquet, December 11, was Dr. Morris Fishbein.——Dr. Allen O. Whipple, professor of surgery, Columbia University College of Physicians and Surgeons, New York, addressed the Orleans Parish Medical Society, New Orleans, December 13, giving the first memorial annual lecture established by the society in honor of the late Dr. Stanford E. Chaille, for many years dean of Tulane University School of Medicine.

MASSACHUSETTS

Personal.—Dr. Charles L. Connor, instructor in pathology, Harvard University Medical School, Boston, has been granted leave of absence in order to accept a temporary position as associate professor of pathology at McGill University, Montreal.

Bills Recommended.—The police commissioner of Boston has submitted to the state legislature a bill prescribing the manner and contents of reports of treatment of wounds caused by firearms. The commissioner of public health has recommended to the legislature a bill to regulate the manufacture, distribution, sale and commercial use of cosmetics. The board of registration in medicine has recommended a bill providing for the appointment of an investigator by the board.

Society News.—Major James F. Coupal, M.C., U. S. Army, physician to the President, addressed the Harvard Medical Society, December 7, at the Peter Bent Brigham Hospital, Boston, on "History of Pathology," illustrated with lantern slides.——Prof. F. Neufeld, director, Robert Koch Institute for Infectious Diseases, Berlin, gave the Cutter Lecture on Preventive Medicine at the Harvard Medical School, November 10; his subject was "Immunity in Its Significance to Epidemiology."——Dr. Rudolph Matas, New Orleans, professor of general and clinical surgery at Tulane University School of Medicine, addressed the Harvard Medical Society, November 2, on "Surgical Treatment of Aneurysm." ——Dr. Charles Macfie Campbell, Cambridge, has been elected president of the Massachusetts Society for Mental Hygiene for the ensuing year, and Dr. Charles E. Thompson, Gardner, secretary.

MICHIGAN

Personal.—Dr. Reynolds C. Mahaney, Owosso, has been elected president of the Michigan Public Health Association, and Dr. William J. V. Deacon, Lansing, secretary.—— Dr. John D. Monroe has been appointed in charge of the Oakland County health department.

Veteran Physicians Honored.—At a recent meeting of the Calhoun County Medical Society, Dr. Willoughby L. Godfrey was presented with a silver loving cup on his fiftieth anniversary as a practicing physician, in recognition of his service to the people of Battle Creek; Dr. William H. Haughey made the presentation address.——The Bay County Medical Society gave a complimentary banquet in October in honor of Dr. John W. Hauxhurst to commemorate his fiftieth year in the practice of medicine. The society presented its guest of honor with a silver water pitcher. Dr. Hauxhurst has practiced continuously in Bay City for fifty years.

Schick Test Clinics.—The state department of health has been conducting clinics for administering the Schick test in the counties where toxin-antitoxin was given last year in demonstration clinics: Baraga, Alger, Presque Isle, Montcalm, Cass, Kent and Genesee. A physician and a nurse from the department perform the test and return the following week to record the result. Certificates were given to those who were immune, and those who were susceptible, as indicated by the test, were advised to have their family physician administer toxin-antitoxin. About 70 per cent of those who were given toxin-antitoxin had Schick tests. Similar clinics were conducted in Ionia and Washtenaw counties a year ago.

Legislative Conference.—Representatives of the state medical society, the two medical schools, state health department, board of registration, the nurses' association, the hospital association, the dental society, the tuberculosis association and several county medical societies, a total of ninety-four, attended a legislative conference at Lansing, November 16, at the invitation of the state medical society, at which President Jackson presided. Each organization set forth its legislative problems. It was decided to create a central legislative bureau comprised of a representative from each organization represented at the conference, to correlate the needs of legislation. It was the opinion of the conference that a bill should be introduced in the legislature making it possible

for counties to employ health officers and establish county health boards, also to employ nurses, dentists and physicians. The conference was addressed by Dr. William C. Woodward of the bureau of legal medicine and legislation of the American Medical Association.

Society News.—Dr. Clark D. Brooks addressed the Wayne County Medical Society, Detroit, December 14, on "Surgical Treatment of Diseases of the Gallbladder."——Dr. Richard L. Sutton, Kansas City, gave an illustrated talk on "African Lion Hunting" before the Detroit Dermatological Society, December 16.——Dr. Frank C. Witter was elected president of the Highland Park Physicians' Club at its clinic, December 2, at the Highland Park General Hospital, and Dr. Charles J. Barone, secretary. Among the guests at the annual meeting were Dr. Irving W. Potter, Buffalo, who demonstrated with lantern slides his method of version; Dr. William Seaman Bainbridge, New York, gave a clinic on tumors; Dr. James E. Sadlier, Poughkeepsie, N. Y., president-elect, New York State Medical Society, spoke on "Preventive Medicine and Postgraduate Medical Study"; Dr. John Phillips, Cleveland, gave a clinic on cardiovascular and pulmonary disease.——Dr. Sumner Merrill Wells, Jr., Grand Rapids, addressed the Graciot-Isabella-Clare County Medical Society, recently, at Alma, on "Pernicious Anemia and Associated Conditions."——Dr. Reuben Peterson, of the University of Michigan, addressed the Grand Traverse-Leelanau County Medical Society, recently, on "Modern Obstetrics."

MISSOURI

Proposed New Medical School.—A committee of physicians under the chairmanship of Dr. John Punton has made a study of the advisability of establishing a medical school as a department of the new Lincoln and Lee University in Kansas City. The committee has recommended that a grade A medical school be established, and the cooperation of local physicians in raising the funds will be sought. The alumni of the old University Medical College have volunteered to raise $150,000. The committee recommended also that the medical school be located downtown in the vicinity of the larger hospitals, rather than on the university site at Seventy-Fifth Street and the state line.

NEW MEXICO

Health Officer Appointed.—Dr. Crawford H. Douthirt has been appointed full-time health officer of Union County to succeed Dr. William H. Enneis, who has accepted a position in West Virginia. Dr. Douthirt was formerly health officer of Union County; he returns to the position with renewed health.

NEW YORK CITY

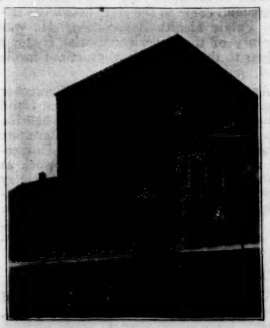
Personal.—Charles H. Herty, Ph.D., has resigned the presidency of the Synthetic Organic Chemical Manufacturers Association of the United States to assume the duties of adviser to the Chemical Foundation, Inc., to which he will devote full time.——Dr. Arthur C. Jacobson has assumed the editorship of *Medical Times*, following the resignation of Dr. Harrie Sheridan Baketel.——Dr. Winfield Scott Pugh has been appointed assistant attending genito-urinary surgeon on the staff of the City Hospital, New York.

One Hundred Thousand Dollars for Conquest of Cancer.—At a dinner given by President Nicholas Murray Butler of Columbia and the Hon. Charles Evans Hughes, in the interest of the American Society for the Control of Cancer, December 15, it was announced that Mr. William L. Saunders, New York, had offered a reward of $100,000 for discoveries of the causation, prevention and cure of cancer. The decision on which the awards will be made is to be reached by the American Society for the Control of Cancer, and approved by the American Medical Association and the American College of Surgeons. The offer has not yet been formally accepted. Information as to how persons who wish to present their discoveries for consideration should proceed will be announced later. Mr. Saunders is chairman of the board of directors of the Ingersoll-Rand Company, director of the Federal Reserve Bank of New York and president of the United Engineering Company. The offer stands for three years from Dec. 15, 1926, and probably will then be renewed, if necessary. Fifty thousand dollars will be given to any person or group who may discover what human cancer is or how it can be positively prevented, and a like sum to any person or group who may discover an absolute cure for human cancer, or the entire $100,000 may be given to the same person or group.

The New York Academy of Medicine.—The formal opening of the new building of the New York Academy of Medicine at Fifth Avenue and One Hundred and Third Street, November 18, was presided over by the president, Dr. Samuel A. Brown, who made a brief address on the services of the academy in medical progress. Dr. Arthur B. Duel, chairman, reviewed the work of the building committee. There was an informal reception and tea, and the guests were invited to inspect the building. Rev. Henry S. Coffin opened the ceremony with prayer. On the previous evening, there was a dinner at the Waldorf-Astoria in honor of the newly elected honorary fellows. The guests, a distinguished company, completely filled the banquet hall. Dr. George D. Stewart presided, and the speakers were Dr. Harvey Cushing, Boston; James J. Walker, mayor of New York; Dr. George E. de Schweinitz, Philadelphia; Dr. William S. Thayer, Baltimore, and Sir Ewan J. McLean, representing the British Medical Association. There was a meeting for the organization of the Academy of Medicine, Dec. 12, 1846, in the New York Lyceum of Natural History, where the meetings continued to be held regularly until March 3, 1847, when quarters were secured in Convention Hall at 179 Wooster Street; other temporary meeting places were New York University and the College of Physicians and Surgeons. The first permanent home was opened in 1875 at 12 West Thirty-First Street. A larger home, to accommodate the growing library and the increasing number of fellows, was constructed at 17 West Forty-Third Street during 1887 and 1888. As long ago as 1909, the library committee called attention to the need for still more room. For several years, plans to enlarge the Forty-Third Street building were considered, although they were never fully satisfactory. The Carnegie Corporation, through its president, Henry S. Pritchett, Ph.D., recognizing the usefulness of the academy to the public, voted, in 1922, to appropriate a million dollars for a new building. A campaign for funds for a site was then undertaken, and 1,313 fellows subscribed $206,161.64, friends of fellows adding $324,922.78. A site was purchased at Sixtieth Street and Park Avenue, but with the change in plans, it was sold, and before the present location was decided on about a hundred sites were considered; seventeen years elapsed between the first discussions for a new home and the opening of the present building. This beautiful structure is Romanesque, stone, six stories high, with an auditorium wing three stories

Main Hallway

Hosack Hall, the Auditorium



The New Academy Building

in height. The book stack occupies the entire southeast section from sub-basement to the top. The third floor mezzanine has eight seminar rooms, where fellows may confer or do special work. The fourth floor contains the offices of the New York State Medical Society, the American Otological Association, the Association for the Relief of Widows and Orphans of Medical Men, and the section meeting room. The fifth floor houses various headquarters, including the *New York State Journal of Medicine* and the New York County Medical Society. The sixth floor contains the administrative offices of the academy. The Carnegie Corporation increased its gift to a total of $1,550,000, and the Rockefeller Foundation has promised $62,500 annually. The work of the Academy of Medicine has in the past been of great service to the public; now that work, along with its service to the profession of medicine, can be extended.

OHIO

Hospital News.—The City Hospital, Coshocton, has been bequeathed $10,000 for the maintenance of a free ward, by the late George M. Burns, St. Louis; Mr. Burns was a native of Coshocton.

Personal.—Dr. Emerson Megrail, assistant professor of hygiene and bacteriology, Western Reserve University School of Medicine, Cleveland, has been granted seven months' leave of absence to work at the Lister Institute, London, under the direction of Sir John C. G. Ledingham.

Increase in Death Rate.—The department of commerce announces that the death rate for Ohio in 1925 was 11.38 per thousand of population, as compared with 11.25 in 1924. There were increases in the rates for influenza, heart disease, nephritis, automobile accidents and enteritis.

Health at Cincinnati.—Telegraphic returns to the department of commerce from sixty-six cities with a total population of 29,000,000 for the week ending December 11 indicate that the highest mortality rate (19.3) was for Cincinnati, and that the mortality rate for the group of cities was 12.8. The mortality rate for Cincinnati for the corresponding week last year was 18.6, and for the group of cities, 12.8.

Dr. Vorbau Goes to Lima.—Dr. Wilhelm H. Vorbau, superintendent of the Institution for the Feebleminded at Orient, has been appointed head of the Lima State Hospital for the Criminal Insane, to succeed the late Dr. Charles H. Clark. Dr. Vorbau was for several years an assistant to Dr. Clark on the staff of the hospital at Lima, and left that hospital last year to take the position at Orient. He will take up his new duties about January 1.

Dr. Kleinschmidt Resigns.—Dr. Harry E. Kleinschmidt has resigned, effective December 15, as chief of the division of child hygiene of the Ohio state department of health, and has been appointed superintendent of the medical service of the National Tuberculosis Association with headquarters in New York. Dr. Kleinschmidt came to the state health department from the Toledo Public Health Association. He was formerly medical secretary of the American Social Hygiene Association and, previous to the World War, practiced medicine in St. Louis.

Director of Clinic Appointed.—Dr. Henry C. Schumacher has been appointed director of the permanent Cleveland Child Guidance Clinic, which begins operation, January 1, when the present Child Guidance Clinic demonstration in Cleveland closes. Dr. Schumacher is a graduate of St. Louis University; he was awarded a fellowship in public health work at Johns Hopkins, and an extramural fellowship in psychiatry by the National Committee for Mental Hygiene. The position of psychiatrist which he vacates at the All-Philadelphia Child Guidance Clinic will be filled by Dr. Harry M. Tiebout, who has been on the staff of the Cleveland Demonstration Clinic.

PENNSYLVANIA

University News.—Alfred N. Richards, Sc.D., professor of pharmacology, University of Pennsylvania Medical School, has been granted a year's leave of absence to study abroad, and is now at the National Institute for Medical Research, London.

Hospital News.—Dr. John Chalmers Da Costà was guest of honor at the fortieth annual banquet of the Association of Ex-Residents of the Philadelphia General Hospital, December 7. Dr. David Riesman was toastmaster, and Dr. Francis J. Dever, Bethlehem, was elected president.

Woman's Auxiliary Benefit.—More than a thousand ladies attended a bridge party given by the Woman's Auxiliary of the Allegheny County Medical Society at the William Penn Hotel, Pittsburgh, December 6, as a benefit for the library of the new Children's Hospital. The auxiliary plans now to place *Hygeia* in all the city and county school libraries.

TENNESSEE

Tristate Medical Meeting.—The program of the forty-third annual meeting of the Tri-States Medical Association (Mississippi, Arkansas and Tennessee) has been arranged to provide an intensive postgraduate course. The speakers, as published in the *Memphis Medical Journal*, include eighteen prominent physicians from nearly all parts of the United States; there being no sections, all can be heard by every one present. The sessions will be held at the Hotel Peabody, Memphis, Feb. 1-3, 1927.

Anatomic Building Dedicated.—The University of Tennessee College of Medicine, Memphis, formally dedicated its new anatomy building, December 16. Physicians in surrounding states were invited to inspect the building. At a dedicatory dinner at the Hotel Peabody in the evening, the speakers were Dr. William D. Haggard, Nashville, past President of the American Medical Association, and Dr. William A. Evans, professor of public health, Northwestern University Medical School, Chicago. This is the first of a group of buildings in a comprehensive plan of development, and for the present will house all the scientific departments except pathology and bacteriology.

UTAH

Society News.—Dr. George G. Richards addressed the Salt Lake County Medical Society, Salt Lake City, November 8, on "Diagnosis of Gallbladder Diseases." At the previous meeting, Dr. Francis A. Goeltz, Jr., read a paper on "Obstruction as a Causative Factor in Renal Pathology." Dr. Edouard Rist, Paris, France, recently addressed the society on "Pitfalls in the Diagnosis of Pulmonary Tuberculosis."

Searchlight in Smoke Abatement Campaign.—A smoke abatement campaign undertaken by the civic authorities of Salt Lake City, in which the University of Utah and the U. S. Department of Commerce cooperated, succeeded in reducing the production of smoke from plants in the industrial districts of the city 95 per cent within a period of about five years. The business district, formerly the center of the smoke cloud, the department of commerce reports, became the clearest part of the city. A lack of funds to continue the campaign caused its temporary abandonment early in 1925 with the result that the remarkable improvement was not maintained. Smoke abatement work is generally based on observations made throughout the day, while night smoke is ignored. In this campaign, an 18-inch low intensity searchlight was mounted on a skyscraper to permit observations in early morning in winter. The fact that the light could be seen for miles, had a good psychologic effect on firemen, although its actual range for detecting smoke ranged only from 300 to 500 yards, depending on atmospheric conditions. An educational campaign was conducted among the householders and the railroads with inspectors instructing firemen in correct firing methods. Data collected by the commission indicated that the saving in fuel due to improved firing amounted to $30,000 a year. A description of this campaign will be mailed, free, on request to the Bureau of Mines, Department of Commerce, Washington, D. C.

WYOMING

Unusual Medical Meeting.—The scientific program of the Northwestern Wyoming Medical Society's meeting at Lovell comprised papers by Dr. Edward W. Thuerer, Billings, on "Goiter"; Dr. Chester E. Harris, Basin, on "Tularemia," and Dr. Edwin Earl Whedon, Sheridan, on "Cataract from the Viewpoint of the General Practitioner." At midnight, the society adjourned to the home of Dr. William W. Horsley; at 2 o'clock the members retired; at 3, they assembled again at the Lovell Cafe for breakfast, and at 4 were "snugly located in duck blinds" which the local physicians had constructed around Byron Lake. An automobile load of ducks was sent into town at 7:30, and at 10:30, the members and their wives sat down to a breakfast of fruit, cantelope and duck, which the ladies of the Methodist Church prepared. A correspondent says, in *Colorado Medicine*, "This was ample reward for traveling the hundred miles which the members averaged to attend the meeting."

GENERAL

Society News.—At the annual meeting of the Southern Surgical Association, Biloxi, Miss., December 16, Dr. Guy L. Hunner, Baltimore, was elected president; Drs. Harley R. Shands, Jackson, Miss., and Lucius E. Burch, Nashville, Tenn., vice presidents; Dr. Robert L. Payne, Norfolk, Va., secretary, reelected, and Dr. Urban Maes, New Orleans, treasurer, reelected. The next meeting will be at Augusta, Ga.—The next meeting of the American Gynecological Society will be in Hot Springs, Va., May 23-24, 1927. The secretary is Dr. Floyd E. Keene, Sixteenth and Walnut streets, Philadelphia.

Standardisation of Anatomic Terminology.—A proposal for the standardization of terminology in anatomy and nosology, submitted by A. de Castro, former dean of the faculty of medicine of Rio de Janeiro, has been brought before the subcommittee on bibliography of the Committee on Intellectual Cooperation of the League of Nations, which decided to submit the proposal to the Health Committee. It has not been possible as yet to draw up an anatomic nomenclature that would be acceptable to all nations, but there already exists a nomenclature known as "Nomina Anatomica," which was adopted by a number of countries after an International Congress held, in 1895, at Basle. Since this nomenclature is an appreciable step toward standardization, the subcommittee on bibliography recommends that scientists belonging to countries not accustomed to using the "Nomina Anatomica" place this terminology in brackets following the national terms used in their textbooks treatises and other scientific publications.

American Association for the Advancement of Science.—The eighty-third meeting of this association will open, December 27, in Weightman Hall, University of Pennsylvania, Thirty-Third and Spruce streets, Philadelphia; thirty-three other scientific organizations are planning to meet with the association. Michael I. Pupin, LL.D., will deliver the address of the retiring president, Monday evening, on "Fifty Years' Progress in Electrical Communication." Liberty H. Bailey, Ithaca, N. Y., president for 1926, will preside. The fourth prize award of the association will be made at this meeting to the author of one of the notable contributions to science presented in this program. The University of Pennsylvania, where most of the sessions will be held, the American Philosophical Society, which has rooms in Independence Hall, and Franklin Institute are the hosts. Section N (Medical Sciences) will meet Tuesday, opening with the address of the retiring president, Dr. Anton J. Carlson, Chicago, on "Tendencies in Research of Biomedical Sciences." There will be a symposium on "Growth in Health and Disease," and papers on the biologic aspects of medical problems. The Society of American Bacteriologists, which meets, December 28-30, will conduct symposiums on "Filtrable Viruses," and "The Teaching of Bacteriology in Institutions Other Than Medical Schools." The American Society of Parasitologists meets, December 28-31. Dr. Charles W. Stiles will deliver the retiring president's address, and the guest of the society will be Prof. George F. Nuttall of Cambridge University, England.

Bureau of Mines' Safety Campaign.—The predominant feature of the activities of the U. S. Bureau of Mines during the fiscal year 1926 was the continuation of the educational campaign to decrease the death and injury rates among the one million miners of the country. Many of the larger bituminous mines have adopted the bureau's plan of rock-dusting to prevent explosions, and a striking example of the efficacy of this method occurred in January, 1926, at the New Orient mine in southern Illinois, where an explosion was localized and the number of deaths held down to five, at a time when about 1,000 men were at work in the mine. The bureau trained during the year 28,041 miners in first-aid and mine rescue methods, making a total of about 200,000 thus trained, in addition to many city firemen, policemen, school pupils and others. Training was conducted in thirty-three states and in Alaska during the year. The bureau staged tremendous explosions at its experimental mine at Bruceton, Pa., the only coal mine in the world devoted exclusively to government safety research, to demonstrate the efficacy of rock-dusting in limiting explosions. The bureau's safety campaign has been extended to the petroleum and natural gas industries, and at numerous points in the oil fields first-aid teams have been organized. The James A. Holmes Safety Association, named in honor of the first director of the Bureau of Mines, has thousands of members making special efforts to advance safety in mines. Thirty new chapters were organized during the year. A carbon monoxide recorder, developed at the Pittsburgh station of the bureau, gives warning to miners in atmospheres containing 4 parts of gas in 10,000 parts of air, and should become useful in the vehicular tunnels of the country now congested by automobile traffic. A new type of gas mask devised to give protection against all gases was developed. Studies recently completed by the bureau demonstrated that voice signals can be transmitted in and out of a mine through 400 feet of strata by using dry cells for electrical energy and modified telephone parts for sending and receiving apparatus. The Bureau of Mines carried on various other researches looking toward the conservation of fuels and the development of new sources of supply.

New County Society Presidents.—The following physicians have recently been elected president of the county medical society indicated:

Dr. Manning L. Allen, Tama, Iowa, Tama County Medical Society.
Dr. Isaac W. Amerman, Nevada, Mo., Vernon-Cedar County Medical Society.
Dr. Henry S. Bartholomew, Lansing, Mich., Ingham County Medical Society.
Dr. Jesse W. Barnes, Stockton, Calif., the San Joaquin County Medical Society.
Dr. Elbridge M. Breniman, Ackley, Iowa, Hardin County Medical Society.
Dr. Harry L. Brockmann, High Point, N. C., Guilford County Medical Society.
Dr. Sidney E. Buchanan, Concord, N. C., Cabarrus County Medical Society.
Dr. Harry M. Coleman, Barron, Wis., Barron-Polk-Washburn-Sawyer-Burnett Counties Medical Society.
Dr. John D. Coons, Lebanon, Ind., Boone County Medical Society.
Dr. Charles A. Crane, Corunna, Mich., Shiawassee County Medical Society.
Dr. Clyde O. Donaldson, Kansas City, Mo., Jackson County Medical Society.
Dr. Arthur D. Donnelly, Bowling Green, Ky., Warren County Medical Society.
Dr. Raymond H. Dunn, South Charleston, W. Va., Kanawha County Medical Society.
Dr. John F. Gilbert, Cleveland, Tenn., Bradley County Medical Society.
Dr. Howard B. Goodrich, Hannibal, Mo., Marion County Medical Society.
Dr. Harry G. Grable, Kokomo, Ind., Howard County Medical Society.
Dr. Willis B. Hardesty, Berthoud, Colo., Larimer County Medical Society.
Dr. Losey L. Harding, Frankfort, Ind., Clinton County Medical Society.
Dr. Llewellyn F. Heath, Georgetown, Ky., Scott County Medical Society.
Dr. William Hibbetts, Texarkana, Texas, the Bowie-Miller County Medical Society.
Dr. Joseph A. Hirsch, Edwardsville, Ill., Madison County Medical Society.
Dr. Andrew D. Hoidale, Tracy, Minn., the Lyon-Lincoln County Medical Society.
Dr. Ralph W. Holmes, Chillicothe, Ohio, the Ross County Medical Society.
Dr. Walter A. Hoyt, Akron, Ohio, the Summit County Medical Society.
Dr. Frank P. Hunter, La Fayette, Ind., the Tippecanoe County Medical Society.
Dr. Robert E. Leatherock, Drumright, Okla., Creek County Medical Society.
Dr. Paul D. Lieberthal, Ironwood, Mich., Gogebic County Medical Society.
Dr. Harry A. Lindsay, Sidney, Ohio, Shelby County Medical Society.
Dr. Louie M. Limbaugh, Jacksonville, Fla., Duval County Medical Society.
Dr. Walter P. McCall, Ennis, Texas, Ellis County Medical Society.
Dr. Liva C. McLain, Bakersfield, Calif., Kern County Medical Society.
Dr. Asa C. Messenger, Xenia, Ohio, the Greene County Medical Society.
Dr. Edward K. Morris, Merrill, Wis., Lincoln County Medical Society.
Dr. Harry A. Neiswander, Pandora, Ohio, Putnam County Medical Society.
Dr. Jesse E. Nixon, Portland, Ind., Jay County Medical Society.
Dr. Eugene P. Norwood, Corsicana, Texas, Navarro County Medical Society.
Dr. Connor O. Reed, Bellingham, Wash., Whatcom County Medical Society.
Dr. John J. Reynolds, Defiance, Ohio, Defiance County Medical Society.
Dr. Charles A. Ringle, Greeley, Colo., Weld County Medical Society.
Dr. James E. Robinson, Temple, Texas, Bell County Medical Society.
Dr. Jesse H. Roth, Kankakee, Ill., Kankakee, County Medical Society.
Dr. Morrell E. Simpson, Bedford, Ind., the Lawrence County Medical Society.
Dr. Proctor Sparks, Ashland, Ky., Boyd County Medical Society.
Dr. John Spicer, Goldsboro, N. C., Wayne County Medical Society.
Dr. Frederick J. Swift, Maquoketa, Iowa, Jackson County Medical Society.
Dr. Joseph S. Thomas, Flushing, N. Y., Medical Society of the County of Queens.
Dr. Charles E. Whitehead, Bozeman, Mont., Gallatin County Medical Society.
Dr. Charles Howard Witmer, Lancaster, Pa., Lancaster County Medical Society.
Dr. Earl A. Yates, Piqua, Ohio, Miami County Medical Society.

Foreign Letters

LONDON

(From Our Regular Correspondent)

Dec. 3, 1926.

Medicine and the Press

The subject of medicine and the press has become topical. At a meeting of the Hunterian Society, Sir Humphry Rolleston expressed his agreement with much of what had been laid down by Sir Thomas Horder at a previous discussion on this subject (THE JOURNAL, November 6, p. 1570). It was important, he said, to remove the impression shown by comments in the press that the medical profession was obstructive or adverse to health propaganda. Education of the public in the "laws of physiologic righteousness" was an essential factor in the campaign against disease. The press was a great educator and its power for good or evil was unrivaled. Some public instruction in preventive medicine should undoubtedly be carried out in the lay press, but the public should be told much about preserving a healthy condition of body and little about the actual details of disease—in fact, only the early symptoms of grave conditions formed really valuable information. There was an essential difference between works on professional subjects and writing in the lay papers for an audience of possible patients. The less healthy people knew about disease, the better for them. A periodic examination by a physician would effectually relieve anxiety. The main question on which the lay press and medical opinion differed was whether or not articles in the lay press should be signed by physicians in practice, since the writers were inevitably advertised thereby and probably estranged their silent brethren. Unsigned medical articles were said to be poor copy for the press, but leading articles on other subjects formed and guided opinion. It seemed inconsistent that the press had unanimously condemned Sir Thomas Horder's suggestion of an advisory board of medical authorities who should guarantee the efficiency of the writer of an unsigned article. No doubt certain articles signed by eminent names had done great good; but if every one were to write, the door was opened to self-glorification and advertisement, and how was a line to be drawn? The press naturally wanted news, but what was new was not necessarily true and the public might well be led astray by honest enthusiasts. It was unlikely that the press would consent to restrict articles to general hygiene. On the whole, it was undesirable that men in practice should write signed articles for the lay press. The idea that an eminent man could do things that a lesser man would not be allowed to do with impunity was widespread, but he did not know of an instance that justified this impression; many persons at the top of the tree had been called on to give an account of themselves.

Dr. E. Graham Little said that it was the intrinsic worthlessness of these contributions to the lay press that was troubling the medical profession; the difficulties of contributing information worth giving were almost insuperable. How far it was possible to convey serious information through the lay press should be the subject of consideration; he did not think that the columns of the lay press were the best place; even if the press would accept such serious articles, the public would not believe them. Reports in the lay press usually extracted the frivolous part of a lecture and ignored its real purpose. The medical papers might be used, at least initially, for the exposition of medical advice to the public. It would be to the advantage of medical writers to learn to express themselves simply and to have the wise censorship of a trained staff of medical journalists. The committee of lay and medical representatives proposed by Sir Thomas Horder as a board of reference would be too cumbrous. There was more serious danger than was realized in giving premature publication to unsubstantiated scientific knowledge, and medical communications might come to be offered first of all to lay papers instead of being submitted to the crossfire of medical criticism. The medical research council was one of the worst offenders as regards early publication. He quoted the publicity given by it to Dreyer's work on tuberculosis and to Gye and Barnard's work on cancer. Surely it would have been better to submit their views to authoritative sponsors than to arrange for them to be broadcast in the daily press. It was better to proceed more cautiously as the British Medical Association research committee did in connection with the Spahlinger treatment of tuberculosis. They had rendered real service to the public because of their caution. The less reputable organs of the press were apt to regard medical subjects as so many opportunities for stunts. Another disadvantage of articles in the lay press was the focusing of the attention of individual readers on their own symptoms, leading to a huge consumption of "patent medicines." A healthy instinct was, he thought, a much better guide to such things as diet than any amount of advice in the papers.

The General Medical Council

At the one hundred and twenty-fourth session of the general medical council, the president, Sir Donald MacAlister, said, in his address, that the medical act of 1926 of the Irish Free State had been continued from August 21 for successive periods of one month, and still by its operation maintained the previous arrangement by which the medical acts of this country were made applicable to southern Ireland. Conferences had taken place between the privy council and other government departments in this country, with representatives of the Free State government on the question of their future medical relations. As a result, proposals had been formulated for an amicable agreement between the governments concerned. This agreement, if duly adopted and ratified, gave promise of a practical modus vivendi which might be generally acceptable. A small committee had been appointed to receive evidence and to make recommendations on the question whether it was desirable to make any, and if so what, alterations in the existing law or practice relating to the preparation or publication of the British pharmacopeia and to its adaptation to the requirements of the British Empire. Reference was made by the president to invitations received from different parts of the empire for visits by representatives of the council, and experiences suggested that as communications, aerial, marine and terrestrial, were gradually improved, the time might come when it would be feasible, as it would be mutually beneficial, to organize frequent and regular, rather than rare and occasional, visits to professional bodies overseas, who were occupied, like them, with problems of medical education and registration.

Outbreaks of Acute Poliomyelitis

School outbreaks of poliomyelitis are rare in this country. A considerable number of cases have occurred in schools at Broadstairs, a seaside town where there are many schools. The question arose whether the schools should be closed and the children sent home. It was referred to Lord Dawson (physician to the London Hospital) and Dr. James Collier (neurologist), who decided that the best course was for the children to remain and the schools to be as far as possible isolated. Parents had of course the option of removing children who were not attacked. Nearly all agreed to allow their children to remain. The pupils were daily inspected, and any who showed the slightest signs of illness were at once removed. The result justified this bold action and the cases ceased to occur after a fortnight. A very different course was adopted for an outbreak which took place at the same

time at Uppingham, a well known public school in the Midlands, where a death from poliomyelitis and a second case occurred. The school physicians decided to close the school. This action has been criticized in the press by the two physicians mentioned. They described it as "an error in judgment which would not benefit the boys and which did disservice to the community. To spread several hundred boys about England, where it is impossible to watch them with the same care as they can be watched at school, is to run the risk of extending the disease throughout the country." The school physicians have replied that, being on the spot, they are the best judges of the matter.

The *British Medical Journal* supports Lord Dawson in condemning the closing of the school as likely to broadcast the disease, as there are unfortunately signs that an epidemic of poliomyelitis is on the move and the boys may act as carriers. An instance has just come to light of a girl being infected by a boy who was taken home from a school. The sound policy is to isolate the patient and to keep all other inmates of the school under systematic daily supervision.

The following table, given by Mr. Chamberlain, minister of health, in answer to a question in the house of commons, shows the number of cases of acute poliomyelitis and acute poliencephalitis in the principal European countries:

Country	First Six Months of 1925				First Six Months of 1926			
	Cases Notified	Deaths	Proportion per Million Midyear Population: Cases	Deaths	Cases Notified	Deaths	Proportion per Million Midyear Population: Cases	Deaths
England and Wales..	132	79	3	2	136	57	3	1
Austria	?	?	?	?	5	?	1	?
Denmark	31	?	9	?	12	?	4	?
Finland	14	?	4	?	8	?	2	?
France	80	?	2	?	70	?	2	?
Germany	131	?	2	?	115	?	2	?
Holland	12	4	2	1	8	?	1	?
Italy	217	?	5	?	97	?	2	?
Norway, towns only.	17	0	21	0	5	1	6	1
Sweden	105	?	17	?	86	?	14	?
Switzerland	24	?	6	?	9	?	2	?

The number of cases in England and Wales during the nineteen weeks ending Nov. 13, 1926, was 891 (twenty-three per million of population), but the number of deaths is not yet available.

GENEVA

(From Our Regular Correspondent)

Nov. 25, 1926.

Centenary of Pinel's Death

The centennial of Pinel's death has been celebrated this year, and, as Professor Archard said, in his discourse at the Academy of Medicine, October 26, Philip Pinel was a curious and noble figure. Born at St. Paul, near Castres, April 17, 1745, he studied theology at Toulouse, but feeling that theology was not his calling, went to Montpellier to study medicine. He then came to Paris and there at first gave himself up to researches in natural history. His name was proposed for the chair of comparative anatomy at the museum, but Cuvier was elected to it. In his medical writings, Pinel attempted to introduce order and precision in medicine, especially in his Nosographie philosophique, the first edition appearing in 1799 and the sixth in 1818. Its success was tremendous throughout the world. It was not a dry enumeration of facts, and it was in it that Bichat said he first derived his idea of his Traité des membranes and his Anatomie générale. It can be said that master and student taught each other, because Pinel, in the successive editions of his work, gave place to Bichat's conceptions on diseases of the systems. Pinel's philosophical and literary tastes brought him to the study of mental diseases. He published his Traité médico-philosophique de l'aliénation mentale in 1809. In it he maintains that the disturbances of the understanding should be treated like any of the ordinary diseases. Esquirol compared Pinel to La Fontaine in goodness of heart, simplicity and modesty. He was professor in the faculty of Paris from 1795 to 1822, and for many years physician to the Salpêtrière. Pinel had his first attack of apoplexy in 1823; the second, in which he died at the age of 81, occurred, Oct. 25, 1826. In the eyes of posterity, Pinel's principal glory is his kindly treatment of the insane both at the Bicêtre and Salpêtrière hospitals.

Traffic in Narcotics

Clandestine traffic in narcotics is at present too easy regardless of rigid national legislation. Measures of control will completely fail if they do not assume a broader international character. At its first assembly, in 1920, the League of Nations formulated the following resolution:

Article 23 of the Pact of the League of Nations provides for the carrying out of measures in respect of the traffic in opium and other harmful drugs; in consequence the assembly of the League of Nations is in accord with the government of the Netherlands, that it is preferable to let the league assume all responsibility which, in the terms of the international convention on opium, falls on the government of the Netherlands in respect of everything concerning data to be collected and the settlement of controversies. The opium commission created by the assembly had, with the council of the league, two essential functions: The first was to give the international convention at the Hague on traffic in narcotics a universal character, and to attach to it those states which were not bound by signature to the peace treaties. The second was to protect the powers interested against the free development of the opium traffic. The outcome was the suppression of certain words in the text of the report, replacing them by others, with the result that those countries in which opium is cultivated retain full liberty to act as they see fit. Mr. S. G. Porter of Pennsylvania said that this act of the league, by making legitimate and encouraging opium traffic for reasons of revenue, destroyed all hope of controlling this international plague by the league. Mr. Porter's opinion assumes especial significance for the reason that, according to some observers, the discussion on narcotic drugs was especially an Anglo-American bone of contention, although a compromise was reached which, in reality, was a victory for England. According to some observers the energetic work done by the United States delegation remained futile, because it had to face nations interested in maintaining free opium commerce. If opium eating is legitimate in one country it is likely to contaminate others. The insidious part played by the diffusion of the opium habit is especially manifest in French Indo-China, where opium is not cultivated. China at present raises alone 15,000 tons of opium yearly, while India produces about the same amount, not to speak of that produced by other countries—figures which show the enormous material interest at play. International conventions—if we may judge from the deliberations of the League of Nations—appear for the time being, at least, unable to cope with such a vast problem.

Inmate Poses as Nurse

From Berlin comes the story of a director of an insane asylum in the vicinity of Berlin who accepted the voluntary services of a woman who presented herself to him as a physician, and who nursed the patients with extraordinary success and devotion. The director thereupon decided to give this excellent lady a permanent position in his establishment and asked to see her diploma, causing her much embarrassment. The director then set about to obtain information respecting the admirable nurse, and found that she had escaped from another asylum while under treatment.

PARIS

(From Our Regular Correspondent)

Nov. 24, 1926.

Antigangrene Serotherapy

Professor Vincent, formerly of the Ecole supérieure du service de santé militaire (Val-de-Grâce), now of the Collège de France, recently described the results of the researches that he has been carrying on for many years on antigangrene serotherapy. In 1915, Dr. Weinberg of the Pasteur Institute used with success a serum prepared from the two organisms most frequently encountered in gangrene; namely, *Bacillus perfringens* and *Bacillus oedematiens.* M. Vincent secured a polyvalent serum that is applicable to complex cases in which one encounters, in addition to the organisms mentioned, *Vibrio septicus, Bacillus fusiformis* and various spirochetes, including *Spirochaeta vincenti,* which he himself discovered many years ago in Vincent's angina.

This polyvalent serum, used during the closing period of the war, gave 90.13 per cent of recoveries, provided complications due to tetanus and streptococcic septicemia did not occur. Often it succeeded in apparently hopeless cases. It prevented also amputation of many limbs. Since the war, this serum has proved its efficacy in a number of organic complications in which the symbiosis of anaerobic bacteria play the principal rôle, and which are often fatal. These anaerobes are found in the intestine in large numbers, where they complicate all traumatisms and ulcerous infections of the mucous membranes. Pulmonary gangrene is amenable to the same treatment when due to the symbiosis of *Spirochaeta vincenti* and *Bacillus fusiformis,* with which may be associated the streptococcus and anaerobic bacilli. Several observers, among whom are Perrin, Bolot, Trabaud, Petren and Flamm, have reported favorable results, often immediate, that they secured from the use of polyvalent serum. According to M. Vincent, it is possibly of value to supplement the treatment with arsphenamines, by reason of their peculiar action on all the spirochetes. For putrid urinary infections, the addition of Vincent's anticolibacillus serum is likewise to be recommended. Remarkable results have been secured also in gangrenous appendicitis with perforation. Drs. Forsy, Duguet and Clavelin inject subcutaneously in such cases from 20 to 40 cc. of the serum on the appearance of the first symptoms, and by applying the serum directly to the peritoneal region, after excision of the appendix, have obtained recoveries in cases that seemed hopeless.

Plan to Make Antityphoid Vaccination Compulsory

Three senators, M. Henri Chéron, Dr. Gallet and Dr. Fernand Merlin, have introduced into the senate a bill that provides for universal antityphoid vaccination, on the same basis as the present legislation requiring vaccination against smallpox. Thus far, antityphoid vaccination has been applied only to the military forces and to the civil personnel in army hospitals. During the first months of the war, the mortality from typhoid amounted to nearly 100,000. From the time vaccination was applied to all the soldiers and nurses, the disease decreased, and, the last year of the war, there was not any mortality from typhoid in the army. By reason of the millions who had been vaccinated during the war, the incidence of typhoid throughout France reached a very low rate. Of late, the rate has been gradually rising, especially among women, who have not been vaccinated to the extent that the men have been. Professor Achard, in the Beaujon Hospital, Paris, observed that, among women nurses caring for typhoid patients, those who escaped the disease had been nurses during the war and had been vaccinated. At present, typhoid vaccination is compulsory for all employees in the hospitals of the Assistance publique (public charities).

It is not going to be an easy matter, however, to get the proposed bill passed. In 1914, just before the outbreak of the war, when the opinion of the Academy of Medicine was asked before making typhoid vaccination obligatory in the army, there was much opposition among physicians. Dr. Labbé, who was a member of the senate, became an ardent advocate of the proposal, with the result that compulsory vaccination triumphed. One of his chief arguments was the excellent results secured with the vaccine in the United States Army. The opinion of French physicians at this time was confused by the arguments presented by the advocates of the two rival vaccines, the Chantemesse and the Vincent. The practicing physicians, if not opposed to the vaccination itself, wished to remain individually the sole judges as to the cases in which it should be employed. When the war broke out a few months later, resistance to the measure had been overcome. If parliament approves the present law as drafted, resistance on the part of physicians will not be encountered. But it is possible that the people will not show much enthusiasm, for many persons vaccinated during the war have retained unpleasant memories of uncomfortable hours that followed. Doubtless, too, the controversy as to the best vaccine and as to the best technic will reappear (the Vincent vaccine sterilized with ether in the cold, and the Chantemesse vaccine sterilized by heat; vaccination by mouth, Lumière's enterovaccine, Besredka's vaccine).

Expert Medical Witnesses in Court

Every tribunal in France has a list of experts, of various kinds, chosen in advance by the president. But the custom has been creeping in of late for lawyers to engage as expert witnesses specialists in mental diseases, charged with discovering in the past life of the accused and, above all, in his antecedents, all sorts of reasons which would show him to be irresponsible or, at least, which would demonstrate diminished accountability. Such a specialist acts not as an unbiased witness but rather as a supplementary advocate. When an expert has already been designated officially by the tribunal and has decided that the accused is responsible for his acts, the specialist engaged by the counsel for the defense takes the stand and combats the conclusions of the first expert. Sometimes the public in the audience chamber becomes involved in the debates, which seem very delectable for the reason that the participants appear equally qualified to express opinions, though the first endeavors to preserve a neutral attitude, being himself an appointee of the tribunal, while the second argues in support of his cause. In recent years, the matter has become still further complicated by the fact that the counsel for the defense has summoned to his aid some specialist whose name is found on the list of official experts but who is not engaged by his tribunal on the day his new client appears in court and therefore considers himself free to accept new duties.

In a recent case tried before the court of assizes of the department Nord, a wealthy woman was on trial for having shot and killed her daughter-in-law, whom she hated. It was alleged that she had fired her revolver into the back of her daughter-in-law's head as the two were driving in the country. The crime had been planned and executed in the most cold blooded fashion, while the motive therefor was of the vilest sort. The young woman murdered was pregnant, and the aged mother-in-law feared division of the estate. The experts appointed by the tribunal decided that the murderess was fully accountable for the deed, and the court imposed the death penalty. But the counsel for the accused summoned as expert witness a specialist in psychiatry, a member of the Academy of Medicine, whose name was on the tribunal's list of experts but who was not engaged on that particular day. This specialist discovered, in the past

life of the accused, slight evidences of morbidity, which showed that she was at times subject to obsessions and to impulsive acts. The official experts of the tribunal were bound by their oath to render an impartial decision, while the expert in the employ of the accused was free to follow his bent. The affair gave rise in the press to numerous comments, some of which cast doubt on the value of expert testimony in general. Medical opinion also became aroused, especially owing to the fact that a similar situation arose in the trial of a foreign countess who had deprived a young woman who had been entrusted to her of a large part of her fortune. The same expert who had figured in the other case, a member of the academy, acting as a free witness, explained in court that the grandfather of the countess, in his early youth, committed certain acts that were hardly compatible with reason. The demand has therefore been made from all sides that eminent authorities who figure in the list of experts shall give expert testimony only at the request of the tribunal.

BERLIN

(From Our Regular Correspondent)

Nov. 27, 1926.

Prize Offering of the Deutsche medizinische Wochenschrift

The *Deutsche medizinische Wochenschrift* has announced in number 49 a prize on the topic, "The Best Course of Medical Study; More Particularly, from the Standpoint of the Best Training for the Practicing Physician." In explanation of the purpose of the prize offering, the *Wochenschrift* makes the following statement: "The Prüfungsordnung für Aerzte of July, 1924 (regulations concerning examinations for prospective physicians), does not meet the justified demands of the medical profession and the medical faculties of our universities. Failing to recognize the mistakes of the previous *Prüfungsordnung*, and ignoring the modifications proposed for the elimination of its essential defects, the provincial governments, or, more precisely, their representatives in the federal council, being influenced by the prevailing economic conditions, would not agree to a lengthening of the period of medical study required, but, owing to an increase in the number of subjects in which candidates for degrees must be examined, they have laid additional burdens on the students and have increased the danger of their dissipating their energy through dabbling in too many subjects. Another main weakness of the new *Prüfungsordnung* lies in the fact that account has not been taken of the very general demand for an extension of the opportunities for practical training. Recognizing the inadequate character of the new *Prüfungsordnung*, the federal ministry of the interior has already decided on its revision. To be sure, the ministry has announced that 'it is not planned to make any sweeping changes amounting to a recast of the existing *Prüfungsordnung*,' but we are sure we can trust the feeling of responsibility that is bound to be awakened in the minds of the members of the provincial and the federal boards and that we can rely on their making more extensive changes when the need for such appears from proposed modifications submitted for their consideration. The medical faculties will certainly not fail to supply the boards with ample material. In order, however, to secure adequate proposals from the medical profession and from students, the editorial department and the publishers of the *Deutsche medizinische Wochenschrift* decided to make a prize offering. Through the treatment of the important problem it is thought that opinions will be collected on the justification of the criticisms that have been passed by authoritative representatives of medical science and practice on the essential character of present-day medicine, and on the modes of thinking and acting of the modern physician, thus throwing light on the question as to whether the medical profession is fully in touch with, and adequately representative of, the spirit of our times. Owing to the limitation of the circles to which our prize offering is directed, only practitioners (not university instructors) and senior medical students (ninth and tenth semesters) will be asked, provided they are subscribers to our journal, to compete. The judges of the contest will be: Geheimrat Dippe of Leipzig, Prof. B. Fischer of Frankfort-on-the-Main, Geheimrat Hansberg of Dortmund, Geheimrat Schieck of Wurzburg, Sanitätsrat Streffer of Leipzig, Sanitätsrat Vollmann of Berlin, and the editorial department of the *Deutsche medizinische Wochenschrift*. The prizes offered are: first prize, 1,000 marks; second prize, 300 marks; third prize, 200 marks, and the fourth and fifth prizes, books published by the Georg Thieme house, to the value of 150 and 100 marks, respectively. Competitive articles must reach the editorial department of the *Deutsche medizinische Wochenschrift*, Berlin-Charlottenburg IV, Schlüterstrasse 53, by April 1, 1927."

Medical Examination of Students

According to a report by Dr. Lothar Loeffler of Tübingen, general medical examinations of students were first introduced in Germany in 1922. Professor Weitz examined in Tübingen, in the winter semester 1922-1923, 1,600 male and 136 female students, or about 90 per cent of the total number of German students attending, while Professor Kuhn examined at the same time 1,528 students, or 80 per cent of the total number in attendance. In both cities, the examinations were made at the instance of the "self-help organizations" of the students, with a view to discovering the more grave cases of disease; particularly, cases of tuberculosis, which at that time were becoming more frequent among the students, and to provide for such patients the care and medical treatment needed. The idea of making the examinations promotive of sport activities, though possibly considered somewhat, was at the time wholly a secondary consideration. Other schools soon followed the example of the two cited. An inquiry made in the spring of 1924 revealed that at that time medical examinations of students were being made in Dresden, Giessen, Hanover, Hohenheim, Münster, Freiburg, Munich, Heidelberg, Stuttgart and Tübingen. In some schools the examinations were compulsory and included all students; in others they were optional, in which case only a part of the students presented themselves for examination. Results of the examinations up to February, 1924, showed that the student bodies were underweight as compared with other classes of the population in the prewar and postwar periods (examinations of recruits for the regular army or the militia), also in comparison with the results of examinations of members of the same strata of society in the prewar period (examinations of students entitled to enlist in the special one-year service of the army). At that time (previous to the spring of 1924), approximately 4 per cent of the students were found to be tuberculous, though only 2.5 per cent presented active lesions. In the meantime, medical examinations of students have been made at several other institutions. An inquiry made in May, 1926, and addressed to all the universities and polytechnic institutions, and to a number of the larger trade schools, showed that such examinations are now made in Berlin (university), Bonn, Breslau (university and polytechnic school), Darmstadt, Dresden, Danzig, Freiburg, Giessen, Göttingen, Greifswald, Halle, Hamburg, Hanover, Heidelberg, Hohenheim, Jena, Karlsruhe, Kiel, Königsberg, Leipzig, Mannheim, Marburg, Munich (university), Münster, Stuttgart and Tübingen. No examinations are made in Berlin (polytechnic school), Brunswick, Frankfort, Cologne, Munich (polytechnic school), Nuremberg, Rostock and Wurzburg. The examination extends in Mannheim to all students but is optional; in Kiel only to

patients and athletes; in other institutions only to the newly matriculated students. In Baden, Bavaria and Wurttemberg, a ministerial decree is the basis for compulsory examinations.

Various measures are employed in the different institutions to insure that all who are required to do so shall present themselves for examination, such as: refusal of matriculation to those who fail to present themselves for examination (Munich, Stuttgart), loss of privileges of health insurance and students' aid fund (Dresden, Freiburg, Göttingen, Greifswald, Halle, Heidelberg, Stuttgart, Tübingen), refusal of admittance to gymnastic drill (Darmstadt, Dresden, Königsberg). At the beginning of each semester, the students receive instructions to present themselves for examination at a certain hour. In university cities, the medical examinations are in the hands of the directors, chief physicians and assistant physicians of the policlinic or the medical clinic, in some instances with the cooperation of other clinical institutions. In the other higher institutions, the examinations are conducted by the physician of the athletic association, by especially appointed physicians, or by a group of practitioners who divide up the work. The clinical examination of all the individual students is usually made by a single physician. Only in Freiburg and Karlsruhe is there division of labor according to the various organic regions of the body. Measurements and determinations with reference to constitutional aptitudes and adaptation to various sport activities, which are carried out with much detail in some institutions (Darmstadt, Freiburg, Munich), are made in some institutions by a single examiner, and in others by a group working together. Urinalysis in every case is the requirement in most institutions. Every institution has its own blanks to be filled out, which vary greatly in length and contents. Entries are made not only for medical observations but also for items bearing on athletics, anthropology and sociology. In each case, detailed advice with regard to various forms of sport is given. A physician who has had special training in the aspects of medicine bearing on athletics and sports is employed for the examination of students in Darmstadt, Dresden, Göttingen, Greifswald, Hamburg, Jena and Leipzig. The Freiburger Sportärztliche Institut, under the direction of Professor Rautmann, has done especially good work. Opinions differ as to the present state of nutrition of the student bodies, as compared with the spring of 1924. An improvement is reported from Dresden, Freiburg, Heidelberg, Munich and Tübingen. The observations with regard to the incidence of tuberculosis vary considerably. For open tuberculosis, the values range from 0.5 to 0.8 per cent; for closed tuberculosis, from 2.0 to 2.5 per cent, so that the total incidence is around 3 per cent. But possibly these figures give too favorable an impression, since they refer mainly to newly matriculated students, a large number of whom have just come from the protection of the parental home.

There has evidently been a change in the purpose of the medical examination of students in that now the discovery of disease and the supplying of medical care and treatment are not such prime considerations as they were, although they will of course remain important factors. Care of the healthy students is being made more and more prominent as the aspects of sport and athletics become more and more emphasized. It is coming to be accepted as an indispensable precondition for participation in athletics that every student shall be examined not only as to the presence of disease but also as to the physical aptitudes and capacity of his body. Accordingly, it is becoming more and more necessary to have at every educational institution a physician who has had the benefit of special training in the aspects of medicine bearing on athletics and sport activities, which fact has been recognized, and apparently to the advantage of the student bodies, at a number of German institutions of higher learning.

Marriages

LE GRAND BREMNER BYINGTON, P. A. Surg., U. S. Public Health Service, Iowa City, to Miss Sybil Alberta Kaa of Victoria, Mont., recently.

CHARLES J. HEINBERG, Pensacola, Fla., to Miss Marian Quest of Polo, Ill., at Chicago, October 12.

MARSHALL M. LAWRENCE to Miss Opal Long, both of Rowana, Ky., at Louisville, in August.

ALFRED L. LEWIS, Amite, La., to Miss Hazel Chidsey of Pascagoula, Miss., November 29.

HENRY A. BENDER to Miss Beulah Bertha Ladage, both of Waterloo, Iowa, November 13.

ANDREW G. STANKA, Grand Ledge, Mich., to Miss Agnes May Smilley, in October.

BURR ROYCE WHITCHER to Miss Jessie Sprowles, both of New York, November 6.

OTTO CHARLES PINC to Miss Ann Greenwald, both of Chicago, in June.

Deaths

Samuel Gilbert Webber, Boston; Medical School of Harvard University, Boston, 1865; member of the Massachusetts Medical Society; formerly professor of neurology at his alma mater and Tufts College Medical School; Civil War veteran; formerly on the staff and superintendent of the Boston City Hospital, and on the staff of the Adams Nervine Asylum; received the Boylston prize in 1866 for an essay on "Cerebrospinal Meningitis"; aged 88; died recently, at the Newton (Mass.) Hospital, of cerebral hemorrhage.

Hamilton Polk Jones ● New Orleans; Medical Department of the Tulane University of Louisiana, New Orleans, 1894; assistant professor of clinical medicine at his alma mater; formerly food and drug commissioner for the Louisiana State Board of Health; served during the Spanish-American and World wars; formerly on the staff of the Charity Hospital; aged 54; died suddenly, December 5, of heart disease.

Orville Jay Wilsey, Amityville, N. Y.; Medical Department of the University of the City of New York, 1878; member of the Medical Society of the State of New York; and the American Psychiatric Association; physician in charge of the Long Island Home; aged 72; died, November 25, of heart disease.

Thomas James Maloney ● St. Paul; University of Minnesota Medical School, Minneapolis, 1901; member of the American Academy of Ophthalmology and Oto-Laryngology; served in France during the World War; aged 47; died, November 25, at St. Luke's Hospital, following a long illness.

Samuel De Witt Bailey, Philipsburg, Pa.; Jefferson Medical College of Philadelphia, 1884; member of the Medical Society of the State of Pennsylvania; past president of the Clearfield County Medical Society; aged 70; died, November 13, of carcinoma of the stomach.

Matthew Sydney Goldman, New York; University and Bellevue Hospital Medical College, New York, 1922; member of the Medical Society of the State of New York; on the staffs of the Fordham Hospital and the Hospital for Joint Diseases; aged 26; died, November 11.

Elbert Earnest Fisher ● Salem, Ore.; Sioux City College of Medicine, 1898; past president of the Polk-Yanhill-Marion Counties Medical Society; member of the Associated Anesthetists of the United States and Canada; aged 56; died, October 21, of septicemia.

George B. McClellan Seager ● Detroit; Michigan College of Medicine and Surgery, Detroit, 1893; formerly mayor and health officer of Adrian and chairman of the school board; superintendent of the Michigan Mutual Hospital; aged 59; died, November 14.

August Matern Sartorius, Jersey City, N. J.; Yale University School of Medicine, New Haven, 1912; president of the laboratories of Reed and Carnrick; served during the World War; aged 38; died, November 2, at the New York Post-Graduate Hospital.

Joseph Van Buren Webb ● Goodrich, Tenn.; University of Tennessee College of Medicine, Memphis, 1908; county health

officer; aged 47; died, November 11, at a hospital in Nashville, of carcinoma of the liver, following an exploratory operation.

Edward Cornelius Briggs ✱ Boston; Medical School of Harvard University, Boston, 1880; also a dentist; since 1915 professor emeritus of materia medica and therapeutics, Harvard Dental School; aged 70; died, November 6.

William Jerris Lewis, Freeport, Maine; Medical School of Maine, Portland, 1907; member of the Maine Medical Association; served during the World War; aged 45; died, September 26, at St. Barnabas Hospital, Portland.

William Warren Myer, Old Forge, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1895; member of the Medical Society of the State of Pennsylvania; aged 54; died, June 4, of septicemia.

Edwin Holmes ✱ Exeter, N. H.; Columbia University College of Physicians and Surgeons, New York, 1895; formerly on the staff of the Englewood (N. J.) Hospital; aged 57; died, October 15.

Richard Catlin Fisher, Melbourne, Fla.; National University Medical Department, Washington, D. C., 1890; formerly a practitioner in Chicago; aged 78; died, October 29, at Butte, Mont.

James Willett Spalding ✱ Hillsboro, Texas; College of Physicians and Surgeons, Baltimore, 1884; aged 73; died, November 16, of cerebral hemorrhage and pneumonia.

Wren Morrow ✱ Tekamah, Neb.; Eclectic Medical College, Cincinnati, 1916; on the staff of the Fraternity Hospital; aged 44; died in November, following a long illness.

C. P. Vincent, Varnville, S. C.; Medical College of the State of South Carolina, Charleston, 1885; aged 73; died in November, at the home of his son in Sanford, Fla.

Marcus Oliver Wright, El Paso, Texas; Medical Department of the Tulane University of Louisiana, New Orleans, 1886; aged 66; died, October 21, of angina pectoris.

Charles E. Bingaman ✱ Palmerton, Pa.; Jefferson Medical College of Philadelphia, 1910; aged 42; died in November, at the Palmerton Hospital, of appendicitis.

McCain Robinson, Lowndesboro, Ala.; Tulane University of Louisiana School of Medicine, New Orleans, 1911; aged 42; died, October 27, of acute nephritis.

Clarence Wilder Whitaker ✱ Worcester, Mass.; University of Vermont College of Medicine, Burlington, 1883; aged 68; died, July 19, of heart disease.

Louis P. Furbish, Mellwood, Ark.; Memphis Hospital Medical College, 1898; member of the Arkansas Medical Society; aged 58; died, October 19.

William H. Wise, Dunkirk, Ohio; Cleveland University of Medicine and Surgery, 1871; aged 78; died in November, following a long illness.

James Carroll Hunt, Brackenstown, Tenn.; Vanderbilt University Medical Department, Nashville, 1901; aged 56; died in November.

John Leonidas Plumlee, Stilwell, Okla.; University of Arkansas Medical Department, Little Rock, 1912; aged 37; died, November 9.

William Cutler Bowers ✱ Bridgeport, Conn.; Medical Department of Columbia College, New York, 1877; aged 75; died in October.

Andrew Harrison Boswell, Spanish Fort, Texas; Baylor University College of Medicine, Dallas, 1904; aged 53; died in November.

William Mackey North, Hammonton, N. J.; Jefferson Medical College of Philadelphia, 1883; aged 68; died, November 13.

Robert Perry Aldridge, Anniston, Mo.; University of Tennessee College of Medicine, Memphis, 1908; aged 50; died, November 7.

Thomas J. Estes, Ardmore, Okla.; Memphis Hospital Medical College, 1900; aged 68; died recently, following a long illness.

Emerson V. Hall, Three Rivers, Mich.; Fort Wayne (Ind.) College of Medicine, 1895; aged 66; died, October 28.

Wiley W. Weaver, Speedwell, Tenn. (licensed, Tennessee, 1889); aged about 72; died, October 11, of nephritis.

John F. Reuter, St. Louis; Marion-Sims College of Medicine, St. Louis, 1901; aged 57; died in November.

E. C. Slosson, Fairhope, Ala. (licensed, Alabama, year unknown); aged 83; died, October 23.

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE JOURNAL'S BUREAU OF INVESTIGATION, OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER GENERAL MATERIAL OF AN INFORMATIVE NATURE

MALT-NUTRINE NOT ACCEPTABLE FOR N. N. R.

Report of the Council on Pharmacy and Chemistry

The Council has authorized publication of the following report.

W. A. PUCKNER, Secretary.

Malt-Nutrine (Anheuser-Busch, Inc., St. Louis) is said to represent:

"The Body-Building Strength of Choicest Hops and Malt Stored up in this unadulterated, uncolored, almost predigested LIQUID-FOOD-TONIC."

It is stated that 100 Gm. contain approximately: Alcohol, 3 Gm.; Maltose (reducing sugars), 16 Gm.; Dextrin, 6 Gm.; Protein, 2 Gm.; Phosphates, 0.35 Gm.; "Hop extractives," 0.20 Gm. The preparation is made by extracting barley-malt with water, boiling the extract with hops, concentrating the liquid and then subjecting it to fermentation "whereby the taste and the palatability of the product is greatly improved." Of the carbonic acid gas formed in the fermentation, two volumes of gas to each volume of liquid are absorbed in the preparation; this it is said "also improves the taste of Malt-Nutrine."

Malt-Nutrine is stated to be "a nutritive tonic" and "not a beverage" and to be indicated in the treatment "of nursing mothers, anemic men and women, convalescents from wasting diseases and the overworked and undernourished." The following therapeutic claims are made for Malt-Nutrine:

"Its principal ingredient is a pure malt extract of selected Northern barley—and from the beginning of history, barley has always been recognized as man's most nutritious food. Malt-Nutrine is also rich in 'Nature's Greatest Aromatic Bitter Tonic'—hops. Shoemaker, one of the world's standard medical authorities, points out that 'The bitter principle of hops acts as a stimulant on the stomach, causing an active secretion of the gastric juices.' The soothing, quieting effects of Malt-Nutrine come from a third ingredient—a fine powder 'lupulin' found on the hop plant and extensively prescribed in the treatment of nervous diseases."

Malt and hops are known better through the qualities they impart to beverages, than through any beneficial therapeutic activity. The claims as to the value of lupulin taken in the form of Malt-Nutrine for the treatment of nervous disorders are not supported by any adequate evidence. Neither hops nor lupulin are to be found among the therapeutic agents listed in the U. S. Pharmacopeia and physicians have practically abandoned their use for such purposes.

Since Malt-Nutrine is to be used as a medicine and not as a beverage, it becomes subject to consideration by the Council on Pharmacy and Chemistry. The Council holds that it is unacceptable for New and Nonofficial Remedies because (1) the therapeutic claims made for it are unwarranted and (2) the name is therapeutically suggestive.

University Examining Boards.—For the rise of some of these so-called therapies the medical profession is not wholly blameless. Had our training schools lived up to their professed standards, had the commercial spirit been kept out of them and their medical graduates been of the right caliber, these quack schools could have been fought with clean hands and clean weapons. Such, however, was not the case. Incompetent practitioners turned out by incompetent schools open the door for all the trouble. The university stimulating scientific study, promoting research and creating a sense of science in the minds of the public is now the ultimate remedy. No community of scientific thought can be created in any other way. The first step must be the passing of the power of conducting examinations for the practice of medicine over to boards appointed by the university, thus freeing the medical profession from the charge of personal motive; then the universities will be in a position to say to the legislatures that there must be common standards in scientific subjects.—Troy, H. M.: *Canad. M. A. J.*, November, 1926.

Correspondence

POPULARIZING HEALTH THROUGH SCHOOL CHILDREN

To the Editor:—In an article published recently in the *American Journal of Public Health*, Dr. Haven Emerson states that "the gain in the health of adults during the past few years is due to the fact that they share in the benefits of health services planned largely for children." In my experience, this statement is substantially true. Efforts to safeguard child health through methods such as are employed in the health curriculum of the New York City public schools have stimulated parents to emulate their own children in matters of good health. Permit me to cite one or two health services, planned for school children, that have resulted in the improvement of their health and have gained the active cooperation of parents.

For the last seven years, the Board of Education of the City of New York has set aside one school day, officially designated as School Health Day, when all academic work is suspended while and until approximately one million school children are tested for defects of acuity of vision, and are observed for evidences of defective teeth, hearing, nasal breathing, nutrition and any other easily discoverable physical defects. The most recent one was held, November 4.

On account of the limited number of school medical inspectors, our teachers have been trained to detect such abnormalities through simple tests and observations, supported by their experience and daily classroom contacts with their pupils. Through a campaign of education, parents have been taught that the confirmation of the teachers' observations and the subsequent treatment rests with physicians.

The purpose of our School Health Day is to facilitate the immediate correction of remediable physical defects observed by our teachers and nurses, or diagnosed by the medical inspectors, and to inculcate in the minds of children and their parents the importance of periodic health examinations. As a result of such health education, thousands of children with physical defects are taken to physicians, either privately or at hospital clinics. Without the stimulus of such a health campaign, sponsored by school and health department officials, it is questionable whether many of these physically handicapped children would have been taken by their parents to physicians for medical advice. These visits afford an opportunity, in the presence of the parents, to give health examinations and advice, in addition to corrective measures that may be indicated. The members of the medical profession have an unusual opportunity also, on these occasions, to interest the parents themselves in periodic health examinations.

For the successful administration of any health program involving children, it is essential to obtain the confidence and cooperation of parents. Our toxin-antitoxin campaign is proof of this statement. In 1918, I proposed the use of the Schick test for the school children of our city, and toxin-antitoxin for the susceptibles. With the executive aid of Drs. Park, Zingher and Schroeder, this work has continued in our public schools so successfully since then that parents are now seeking toxin-antitoxin immunization against diphtheria for preschool age children from their private physicians. In the eight years that this work has been carried on so effectively, not one of the 500,000 immunized children has been treated without the written consent of the parents. When an adult population subscribes to a new health measure in such overwhelming numbers, the conclusion is that the public is ready to cooperate with the medical profession, if these measures are properly brought to their attention.

If lay organizations such as school and health boards have gained the confidence of parents to submit their children and themselves to periodic health examinations, and to seek aid in preventive health measures, it is essential that the medical profession continue to hold this confidence through the active practice of modern medicine.

I. H. Goldberger, M.D., New York.
Assistant Director of Educational Hygiene, Board of Education.

Queries and Minor Notes

Anonymous Communications and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

ELECTRIC NEEDLE FOR REMOVAL OF EYELASH

To the Editor:—Can you tell me whether the electric needle has been used with much success in entropion, for the removal of the eyelashes? Also, if it has, possibly you can tell me where it is done.

M.D., Illinois.

Answer.—Misplaced eye lashes, no matter whether they occur in entropion, trichiasis or from some other cause, have been removed for a great many years with the electric needle. The procedure is extremely simple, although somewhat painful unless the lid has been properly anesthetized. A fine cambric needle, connected with the negative pole of a galvanic current of from ¼ to 2 milliamperes, is inserted carefully into the follicle of the hair to be removed and the current turned on for from one to two minutes. The follicle is thereby destroyed and the hair does not grow again. Nearly every oculist has the necessary equipment for this work.

LEUKOPENIA WITH SPLENIC HYPERTROPHY

To the Editor:—The hematologic report presented here is typical of a patient with an enlarged spleen of three years' duration, which followed an attack of influenza.

Red blood cells	4,280,000 per cubic millimeter
Hemoglobin	80%
Color index	0.93
Leukocytes	3,100 per cubic millimeter
Differential count:	
Polymorphonuclear leukocytes	74%
Lymphocytes	19%
Large mononuclears	3%
Transitionals	0%
Eosinophils	4%
	100%

Microscopic appearance: The red blood cells are fairly normal in size, shape and staining quality. We find the same leukopenia as before, for which there is no explanation in the rest of the blood count.

I am unable to find any reference to a leukopenia associated with splenic hypertrophy, and should like to know whether the leukopenia might have any significance in this regard. The patient has no symptoms other than a moderate lassitude. Please omit name.

M.D., Michigan.

Answer.—With so little information regarding the patient, it is hard to do more than suggest a list of the possibilities, which are many.

One of the so-called splenic anemias must be considered. Banti's disease could show such a picture, and it might exist for months or years before the onset of the more severe anemia, gastric symptoms, hemorrhages or portal stasis. There is a leukopenia, but usually a lymphocytosis, due to an actual decrease in the leukocytes. In this connection syphilis must be considered, as some investigators have adduced evidence that Banti's disease is syphilis. Certainly many cases are. Early syphilis may show a spleen, but there is a leukocytosis, especially in the secondaries. Late, however, it could show this picture.

Gaucher's disease shows an enlarged spleen and a leukopenia. Early in the disease there might be nothing but an enlarged spleen, a leukopenia, and a very moderate anemia. There is no constant cytologic picture characteristic of the white count. It, too, is very slow in its progress.

In hemolytic icterus there is also frequently a leukopenia, or, rather, there usually is. Here, also, there is an enlarged spleen. The jaundice may be very slight. This disease is

very slowly progressive, and may last for years, with little in the way of symptoms. The congenital form usually dates back to childhood. The sporadic or acquired form may follow some relatively slight infection or illness.

Malaria must always be considered with an enlarged spleen. An old chronic malaria does some very freakish things. It could show the spleen and the blood picture, and a recrudescence might be very atypical, readily classified as an influenza.

Benzene poisoning causes a leukopenia, and early the reds may not be so much affected, although usually when the patient comes to a physician there is a fairly well marked anemia. The spleen may be enlarged. Benzene poisoning is not so uncommon, as benzene is used considerably in industry.

In pernicious anemia a leukopenia is frequent, but when present the red count also is usually down. But the red count may stay up for a long time. An enlarged spleen is not common. A Price-Jones count would settle that.

Leukemia often shows a leukopenia, but not for long, and the differential count would show it.

A splenic form of Hodgkin's disease may show a leukopenia, with nothing characteristic in the differential count.

Malnutrition may show a leukopenia, but that would not account for the enlarged spleen, nor would such drugs as sulphon methane atropine, camphoric acid, tannic acid or picrotoxin which cause a leukopenia.

Tuberculosis is credited with a leukopenia, but the count is usually normal or increased. It may occur, but usually in the miliary forms, or in the glandular forms, when there is no secondary infection. But that would not account for the spleen, except in the miliary form, which is out of the question here.

ORGANOTONES

To the Editor:—Can you give me any information on Cole's Organ-O-Tones No. 19, as per enclosed card?

CHARLTON S. HARRIS, M.D., Florida.

ANSWER.—More than a year ago THE JOURNAL published a note on "Organ-O-Tones No. 19," which is one of a series of "shotgun" pluriglandular mixtures marketed by the Cole Chemical Company and "pushed" vigorously as an "obesity" remedy, largely by means of postcards which tell nothing of the ingredients of the preparation. According to advertising in our files, however, "Organ-O-Tones No. 19" is said to contain: "Thyroid substance," ½ gr.; "Pituitary (whole)," ¼ gr.; "Phytolaccin," ½ gr.; "Apocynum (P. E.)," ¼ gr.; "Organ-O-Tones No. 12," 3½ gr. "Organ-O-Tones No. 12" is said to contain "Sodium Bicarbonate," 50 parts; "Potassium Bicarbonate," 32 parts; "Calcium Glycero-Phos.," 8 parts; "Calcium Phos. (dibasic)," 8 parts; "Magnesium Phosphate," 2 parts.

Could there be a more typical shotgun preparation! The complexity of the formula is exceeded only by the obviousness of the conclusion that the "Thyroid substance" is the ingredient intended to do the business, namely, to procure weight reduction. Organ-O-Tones No. 19 is, in effect, just another of the dangerous thyroid "anti-fat" nostrums to which a great deal of attention has recently been directed. Reid Hunt and Atherton Seidell called attention more than sixteen years ago to the misuse of thyroid in such preparations. H. S. Plummer and W. M. Boothby (THE JOURNAL, Oct. 25, 1924, p. 1333) refer to this practice as follows: "The use of thyroid for weight reduction is, however, not a procedure to be recommended unless the effect can be carefully followed by basal metabolic rate determinations or by one conversant with the clinical symptoms of overdosage."

DEXTROSE IN DIABETIC COMA

To the Editor:—I notice in the treatment of acidosis due to diabetes that dextrose is recommended in treating the coma, regardless of the fact that sugar may be found in the urine, and I am at a loss to account for this. Insulin is used to oxidize the excess sugar in the blood when diet alone does not control, and yet in this coma sugar is deliberately thrown into the blood with insulin to oxidize it. What is the basis for this line of treatment, and is it the best treatment in those reactions accompanied by dyspnea, diarrhea, vomiting, coma without the tremors, and sweating due to an overdose of insulin? Please omit name. M.D., Oregon.

ANSWER.—A review of current opinion regarding the use of dextrose with insulin in the treatment of diabetic acidosis and coma shows clearly a marked divergence of such opinion. Just as many workers advise the use of dextrose as reject it. The use of dextrose is based on safety. If one can assume a steady high blood sugar level, insulin used alone until the blood sugar becomes normal should be perfectly safe, as the high blood sugar indicates an ample store of mobile sugar available for oxidation by the insulin. Excess of urinary sugar indicates the same thing. However, when one is not perfectly sure of the excessive store of sugar, dextrose given with the insulin allows a wide margin of safety to prevent the insulin reaction of hypoglycemia. Also, there is some recent work suggestive that extra dextrose facilitates the action of insulin. As far as clinical results count, there seems to be no difference in the reported cases.

If by "those reactions accompanied by dyspnea, diarrhea, vomiting, coma without the tremors and sweating due to an overdose of insulin" is meant insulin hypoglycemia, the proper treatment is dextrose intravenously.

ACID TREATMENT OF PERNICIOUS ANEMIA

To the Editor:—I have followed out suggestions in various articles in THE JOURNAL covering the acid treatment of pernicious anemia, and have been amazed with the result—especially one case with a complicating pulmonary tuberculosis. I would appreciate some definite information as to the physiologic or biologic action of dilute hydrochloric acid in this condition. T. A. MCAMIS, M.D., Lawrenceburg, Tenn.

ANSWER.—The use of hydrochloric acid in pernicious anemia has been advised and practiced for many years. There are at least two theories on which this form of treatment has been based. In most patients with pernicious anemia, hydrochloric acid is absent from the gastric secretion and acid has been given in treatment in the attempt to replace the absent secretion. As far as it goes, the ingested acid may aid in digestion, but the maximal dosage possible falls far short of an adequate replacement of the normal secretion.

Another theory as to the etiology of pernicious anemia assumes that infection of the mouth with frequent pyorrhea and glossitis bears a causal relation to the disease, and that the failure of secretion of hydrochloric acid removes a powerful bactericidal element which normally protects the body from infectious and toxic material entering by way of the stomach. On this theory, hydrochloric acid, which is itself a strong antiseptic even in dilute solutions, is given before meals and at night when the antiseptic action of the acid will be less interfered with by the buffer action of salts, and substances contained in the food in the stomach. Many patients seem to do well when given hydrochloric acid in this way, and the persistent use of the acid before meals and at night has frequently been followed by remissions of long duration.

Such striking and sometimes unexpectedly favorable results may invite an unwarranted optimism which, however, is tempered by a careful scrutiny of the natural history of pernicious anemia. The course of the untreated disease is typically up and down, with sometimes long remissions. Patients whether treated or untreated may die after a rapid downward course of only a few weeks or a month, or may live for many years. In attempting the evaluation of any treatment, whether by hydrochloric acid, iron, arsenic, splenectomy, curative transfusions, low protein diet, high protein diet or a diet rich in vitamin A, one is always confronted with the task of supplying adequate clinical controls, a task unusually difficult in so variable a disease as pernicious anemia.

INSULIN FATTENING

To the Editor:—The abstract on "Insulin Fattening" by A. Lublin (THE JOURNAL, October 16, p. 1342) shows that "insulin seems to have a tendency to promote the formation of fat from carbohydrates," and this confirms Falta in advocating fattening by forced feeding under the influence of insulin. Dr. W. W. Richardson in a recent study of presumably curable mental cases (*Atlantic Medical Journal*) found that 75 per cent gave a history of recent loss of weight, and he concludes that "a gain in weight must be produced in at least certain mental cases before mental improvement can occur." The question occurs to me, Could insulin fattening be used in mental cases? Can you advise me in this matter? M. T., Philadelphia.

ANSWER.—Insulin accelerates the utilization and storage of dextrose (*d*-glucose) in general. It increases the rate dextrose is oxidized, polymerized and reduced. One who desires to fatten any patient can do so in only one way; i. e., by giving a diet containing more calories than the patient expends in a day. If there is difficulty in making a patient eat the amount of food needed to do this, insulin may perhaps help by creating more appetite, provided the dosage is properly adjusted. However, if a patient is able to eat and digest a given diet sufficient to make him gain weight on his own natural insulin supply, the advantages of extra insulin by the hypodermic route would seem questionable.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 11-14. Chairman, Dr. S. W. Welch, Montgomery.

ARIZONA: Phoenix, Jan. 4. Sec., Dr. W. O. Sweek, 404 Heard Bldg., Phoenix.

CALIFORNIA: Los Angeles, Jan. 31 to Feb. 3. Sec., Dr. Charles B. Pinkham, 906 Forum Bldg., Sacramento.

CONNECTICUT: State Board of Healing Arts (prerequisite to examination), Feb. 12. Sec., Dr. Charles M. Bakewell, Box 1895, Yale Station, New Haven.

DISTRICT OF COLUMBIA: Jan. 11. Sec., Dr. Edgar P. Copeland, Suite 110, 1801 Eye St., N. W. Washington.

HAWAII: Honolulu, Jan. 10-13. Sec., Dr. A. L. Davis, 1254 Emma St., Honolulu.

ILLINOIS: Chicago, Jan. 11-13. Supt. of Registration, Mr. V. C. Michels, Springfield.

INDIANA: Indianapolis, Jan. 11. Sec., Dr. William T. Gott, Crawfordsville.

KANSAS: Topeka, Feb. 8. Sec., Dr. Albert S. Ross, Sabetha.

MINNESOTA: Minneapolis, Jan. 4-6. Sec., Dr. A. E. Comstock, 636 Lowry Bldg., St. Paul.

NATIONAL BOARD OF MEDICAL EXAMINERS: Parts I and II, Feb. 9-11. All applications should be in by Jan. 9. Sec., Dr. John S. Rodman, 1600 Walnut St., Philadelphia.

NEW YORK: Albany, Buffalo, New York, Syracuse, Jan. 24-27. Chief, Professional Examinations Bureau, Mr. Herbert J. Hamilton, Albany.

NORTH DAKOTA: Grand Forks, Jan. 4-7. Sec., Dr. G. M. Williamson, Grand Forks.

OREGON: Portland, Jan. 4-6. Sec., Dr. M. K. Hall, 816 Pittock Block, Portland.

PENNSYLVANIA: Philadelphia, Jan. 25-29. Mr. C. D. Koch, Director, Professional Education Bureau, Harrisburg.

RHODE ISLAND: Providence, Jan. 6-7. Sec., Dr. B. U. Richards, State House, Providence.

SOUTH DAKOTA: Pierre, Jan. 18. Director, Dr. H. R. Kenaston, Bonesteel.

UTAH: Salt Lake City, Jan. 4-5. Director, Mr. J. T. Hammond, 412 State Capitol Bldg., Salt Lake City.

VERMONT: Burlington, Feb. 8-10. Sec., Dr. W. Scott Nay, Underhill.

WISCONSIN: Madison, Jan. 11. Sec., Dr. Robert E. Flynn, 315 State Bank Bldg., La Crosse.

WYOMING: Cheyenne, Feb. 7-8. Sec., Dr. G. M. Anderson, Cheyenne.

New Mexico April Examination

Dr. W. T. Joyner, secretary of the New Mexico Board of Medical Examiners, reports the written examination held at Santa Fe, April 12-13, 1926. The examination covered 11 subjects and included 100 questions. An average of 75 per cent was required to pass. Two candidates were examined, both of whom passed. Eight candidates were licensed by reciprocity. The following colleges were represented:

College	PASSED Year Grad.	Per Cent
University of Nebraska College of Medicine	(1921) 81 (1925)	87

College	LICENSED BY RECIPROCITY Year Grad.	Reciprocity with
College of Physicians and Surgeons, Little Rock	(1910)	Arkansas
University of Colorado School of Medicine	(1924)	Colorado
Hospital Medical College, Eclectic, Atlanta	(1909)	Georgia
Indiana University School of Medicine	(1921)	Indiana
Baltimore University School of Medicine	(1896)	Kansas
St. Louis University College of Medicine	(1925)	Missouri
University of Buffalo Dept. of Medicine	(1904)	Utah
Ohio State University College of Medicine	(1925)	Ohio

Oregon July Examination

Dr. Marshall K. Hall, secretary of the Oregon Board of Medical Examiners, reports the written examination held at Portland, July 6-8, 1926. The examination covered 11 subjects and included 110 questions. An average of 75 per cent was required to pass. Of the 40 candidates examined, 38 passed and 2 failed. Five candidates were licensed by reciprocity. The following colleges were represented:

College	PASSED Year Grad.	Per Cent
Stanford University School of Medicine	(1926)	84.5
University of California Medical School	(1926)*	86.8
Northwestern University Medical School	(1926)	83.6
Rush Medical School	(1926)	86.8, 87.8
Harvard University	(1923)	86.5
Washington University School of Medicine	(1923)	84.2
University of Oregon Medical School	(1922)	82.4,
1925) 84.1, (1926) 79.2, 81.2, 81.4, 81.8, 82.6, 82.7, 83.3, 83.5, 83.9, 84.5, 84.6, 85.1, 85, 85.7, 85.8, 86.2, 86.4, 86.6, 86.6, 86.8, 87.1, 87.3, 87.4, 87.6, 87.9, 88.6, 88.7, 92.4		
Queens University Faculty of Medicine	(1923)	83.1

College	FAILED Year Grad.	Reciprocity with
Southwest School of Medicine, Kansas City, Mo.	(1916)	40
University of Oregon Medical School	(1925)	75.2†

College	LICENSED BY RECIPROCITY Year Grad.	Reciprocity with
Rush Medical College	(1925)	Minnesota
Medico-Chirurgical College, Kansas City	(1905)	Washington
St. Louis University School of Medicine	(1926)	Kansas
Jefferson Medical College of Philadelphia	(1889)	Washington
University of Pennsylvania School of Medicine	(1923)	California

* This candidate has finished his medical course and will receive his M.D. degree on completion of a year's internship in a hospital.

† Failed in three subjects only.

Book Notices

ANNUAL REPORTS OF THE CHEMICAL LABORATORY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1924-1925. Paper. Price, postpaid, $1.25. Pp. 199. Chicago: American Medical Association, 1926.

The latest addition to the series of reports is a manual representing the years 1924-1925. The contents are divided into three parts. The first part contains reprints of articles published by the members of the staff in various scientific publications. The second part contains reports extracted from THE JOURNAL and from *Hygeia*, and in the main are exposés of the composition of widely advertised secret remedies or the fallacies of certain chemical "assertions." The third part contains reports not previously published; these are largely results of investigation of the newer worth while additions to materia medica, many of them of a purely scientific and investigative nature, such as confirmation of manufacturers' statements or elaboration of new standards. The volume is of general interest to the physician because it gives him not only information on secret remedies, but also accurate comparative results on classes of preparations such as agar and petrolatum emulsions, which contain only a small amount of agar; bismuth tartrate preparations (which vary widely in composition); market specimens of cinchophen—all equally good, but with great variation in price, and standardization of diuretics such as merbaphen and theocalcin. The volume will be especially valuable to those interested in the development and standardization of drugs, as it contains the methods that have been used in the analysis and control of these preparations; in fact, the details of analysis are in themselves short monographs on the quantitative estimation of pharmaceuticals and offer sources to others as "trail blasters." The book is fully indexed and can be used for quick reference.

HEALTH CONTROL IN MERCANTILE LIFE. A Problem of Conserving Human Energy. By Arthur Brewster Emmons, 2d, A.B., M.D., Director, Harvard Mercantile Health Work, Boston. Cloth. Price, $3. Pp. 234, with illustrations. New York: Harper & Brothers, 1926.

This unusual contribution to modern medical and public health education opens with a dedication to Dr. Frederick Cheever Shattuck, who "had the vision to see the possibilities for good of mercantile hygiene as a branch of industrial hygiene and as a concrete expression of preventive medicine." It was planned to make available to stores, banks, offices and other industrial or commercial groups the experience and knowledge assembled by a special study of health conditions made over a period of six years. Twenty-five mercantile establishments provided the money for a sanitary survey of their individual places of business and put into effect the recommendations based on these surveys. A community representing the heads of the concerns and the medical department of Harvard University guided the work.

The results of the study made in the mercantile establishments more than confirmed all that guides modern personal and public hygiene. Much depends on the manner in which the sixteen hours spent outside the store are used. Employees will avail themselves of good medical advice if it is made easily available to them. Mental hygiene is almost as important for workers as is physical hygiene. Problems of ventilation, lighting and noises are significant in the store as in the factory. The establishment of a store health department yields returns justifying the financial outlay. The store physician may make examinations previous to employment and periodic physical examinations of employees. The store nurse

and visiting nurse supplement his work. Sanitation, supplies, the health of executives, the store dental service and mutual benefit associations are all phases of the work that should have consideration. Unquestionably the first serious work on health control in mercantile life, this volume raises certain points for consideration. Many physicians view with anxiety if not with dread and alarm present trends toward contract medical practice. If the family physician is to have periodic physical examination as the bulwark of his practice how is he to be related to the $5,000 a year store physician who is doing the same work? The store physician will treat minor injuries and the store nurse will visit and advise with employees slightly ill at home. Do these patients on what are presumably adequate salaries from the store merit free and contract service? Is it for the good of the patients that they be treated with this type of service or is it preferable for their self-respect that they receive adequate payment for their work as individuals, that they be advised to select good physicians and to remunerate them adequately for their work? No doubt the experiments constantly being made with these problems will develop desirable solutions. The present volume is not only a guide to store health practice but the record of six years of experiment with such practice. It is worth the time of any one interested in any of the aspects of the situation that have been mentioned.

NERVÖSE HERZERKRANKUNGEN U. IHRE BEHANDLUNG. Von Dr. Lilienstein und Prof. Dr. Kastan. Second edition. Paper. Price, 1.20 marks. Pp. 32. Leipsic: Repertorienverlag, 1925.

Since the war the frequent occurrence and the importance of functional cardiac disorders in those with anatomically sound hearts has become more commonly recognized than before. Because of the similar subjective symptoms and the different prognosis and treatment, it is important that they should be differentiated. This little booklet is an account written for the general practitioner of such underlying factors as psychic trauma, disturbances of internal secretion, infection, and the diagnosis and differential diagnosis of such cardiac neuroses, and their treatment. Under treatment are considered diet, psychotherapy, hydrotherapy, massage and other forms of physiotherapy, and a section on drug therapy. The authors state that they are using less and less drug treatment themselves, but offer the physician a wide selection of prescriptions, some of at least debatable value. Specimen diet sheets and forms for prescribing exercise are appended. For so small a booklet, there is much of value.

RHEUMATISM: Its Meaning and Its Menace. By Lewellys F. Barker, M.D., and Norman B. Cole, M.D., Cloth. Price, $1.50. Pp. 166. New York: D. Appleton & Company, 1926.

Almost every one thinks he knows what rheumatism is. Practically every one complains on occasions that he is suffering with its twinges. This volume is planned for the layman, and should do much to inform people about the various types of disease commonly called rheumatism and the methods of medical control. The authors have apparently been at great pains to present their material in simple language, and they accompany it with a glossary indicating their inability to discuss the subject without technical terms. A glossary is a nuisance, and is probably best avoided by defining each of these technical terms as it is used and repeating the definitions on occasion until they are familiar to the reader.

OPHTHALMIC NEURO-MYOLOGY. A Study of the Normal and Abnormal Actions of the Ocular Muscles from the Brain Side of the Question. By G. C. Savage, M.D., LL.D. Second edition. Cloth. Price, $3. Pp. 227, with illustrations. Nashville, 1926.

In this volume the author presents his most recent conceptions of the mechanism controlling the ocular muscles. In a former edition, he emphasized the presence of eight brain centers which control ocular movements. In the present edition, seven pages of the work have been rewritten to urge that there are only two axes of ocular rotation, the vertical and the transverse, and that every possible rotation takes place around one or both of these. Rotations up and down take place around only one axis—the transverse—and it is fixed. Rotations right and left are around a fixed vertical axis. All oblique rotations take place around the two axes while they themselves are in motion. The conception carries on to the statement that the rotation around the one axis sets the other axis in motion, and vice versa. Another feature of the new edition is a description of the De Zeng monocular phorometer. The book is quite technical and will obviously appeal to the specialist in ophthalmology who is familiar with the mechanism of the muscles of the eye and with the theories of their activity.

ARCHERY. By Robert P. Elmer, M.D. Cloth. Price, $5. Pp. 456, with illustrations. Pinehurst, N. C.: Archers Company, 1926.

Among the outdoor sports that continue to attract many persons, the use of the bow and arrow has always had a prominent place, perhaps largely because of the historical background of this sport, and also because it brings into play accuracy, exercise, sportsmanship and many other factors. This book has especial interest because its author is a physician, and also because many other physicians have been interested in archery and have made important names in its promotion. Among the most important have been Dr. Henry B. Richardson, three times champion of the United States, and winner of the Great Britain tournament in 1908, and Dr. Saxton Pope, who has hunted wild animals successfully with the bow and arrow. Those interested will find the volume by Dr. Elmer a complete compendium of important knowledge on the subject.

LEHRBUCH DER TOPOGRAPHISCHEN ANATOMIE MIT BESONDERER BERÜCKSICHTIGUNG IHRER ANWENDUNG. Von John Blumberg, Dozent und Vorstand des Chirurgisch-Anatomischen Institutes an der Universität Dorpat (Tartu) in Estland. Paper. Price, 21 marks. Pp. 486, with 152 illustrations. Berlin: Urban & Schwarzenberg 1926.

Blumberg says he is a surgeon. He is evidently also an anatomist. This book marshals the ever accumulating facts of anatomy in an order convenient to the clinician and surgeon. In every part of the body the regional anatomy is presented, and then those special features of it which lend themselves to study by clinical methods of examination are particularly reviewed in connection with that method. Of the illustrations, twenty-six are full page plates. Most are large and include extensive areas. Nearly all are colored in a manner that adds much to their value. Most are new, made by a Dorpat artist from special preparations for this work. The book should be valuable to advanced students and practioners.

Books Received

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

A TEXTBOOK OF EMBRYOLOGY. By Harvey Ernest Jordan, A.M., Ph.D., Professor of Histology and Embryology, University of Virginia, and James Ernest Kindred, M.A., Ph.D., Associate Professor of Histology and Embryology, University of Virginia. Cloth. Price, $7. Pp. 613, with 304 illustrations. New York: D. Appleton and Company, 1926.

Excellent text beautifully presented incorporating modern methods of presentation of its subject.

DER HEUTIGE STAND DER CHEMOTHERAPEUTISCHEN CARCINOMFORSCHUNG. Von Dr. med. N. Waterman, Biologe am Laboratorium Antoni van Leeuwenhoekhuis (Niederl. Institut für Krebsforschung) Amsterdam. Paper. Price, 6.60 marks. Pp. 74, with 37 illustrations. Berlin: Julius Springer, 1926.

A review of chemotherapy in cancer with the opinion that a practical method will yet appear.

TABULAE BIOLOGICAE. Herausgegeben von C. Oppenheimer, und L. Pincussen. Band III: Allgemeine Chemie. Konstanten chemischer Verbindungen. Chemie der Organe. Stoffwechsel. Grösse und Maassen-Verhältnisse beim Menschen. Pharmakologie, Immunität. Bearbeitet von Prof. Dr. H. Aron und Anderen. Paper. Price, $15. Pp. 829. Berlin: W. Junk, 1926.

Collection of biologic tables with valuable statistical data.

BEHRINGWERKMITTEILUNGEN. Von E. v. Behring. Heft 5—Die Lipatrentherapie der Tuberkulose. Von Direktor Dr. Kurt Klare, Leitender Arzt der Prinzregent-Luitpold-Kinderheilstätte Scheidegg. Paper. Pp. 51. Marburg-Lahn: Behringwerke, 1926.

Announcement of new attempt at chemotherapy of tuberculosis.

THE DISEASES OF INFANCY AND CHILDHOOD: For the Use of Students and Practitioners of Medicine. By L. Emmett Holt, M.D., Sc., D.LL.D., and John Howland, A.M., M.D., Director of the Harriet Lane Home. Ninth edition. Cloth. Price, $8.50. Pp. 1018, with illustrations. New York: D. Appleton and Company, 1926.

Newest edition of standard textbook of pediatrics.

BAKTERIOLOGIE INSBESONDERE BAKTERIOLOGISCHE DIAGNOSTIK. Von Prof. Dr. K. B. Lehmann, und Prof. Dr. R. O. Neumann. 1. Band: Technik, allgemeine Diagnostik, Atlas. Lehmann's medizinische Handatlanten, Band X/1. Seventh edition. Cloth. Price, 20 marks. Pp. 172, with illustrations. Munich: J. F. Lehmann, 1926.

Atlas with good plates of the various bacteria.

THE ORDEAL OF CIVILIZATION: A Sketch of the Development and World-Wide Diffusion of Our Present-Day Institutions and Ideas. By James Harvey Robinson. Cloth. Price, $5. Pp. 769, with illustrations. New York: Harper & Brothers, 1926.

An account of human relationships and their development.

THE CONQUEST OF CIVILIZATION. By James Henry Breasted. Cloth. Price, $5. Pp. 717, with illustrations. New York: Harper & Brothers, 1926.

An outline of man's emergence from nothing into the complex life of today.

ŒUVRES DE PASTEUR. Par Pasteur Vallery-Radot, médecin des hôpitaux de Paris. Tome IV—Études sur la maladie des vers à soie. Paper. Price, $5.50. Pp. 761, with illustrations. Paris: Masson & Cie, 1926.

Another volume in the collection of the writings of Pasteur.

UROLOGIE UND IHRE GRENZGEBIETE: Dargestellt für praktische Ärzte. Von V. Blum, A. Glingar und Th. Hryntschak. Cloth. Price, 16.50 marks. Pp. 318, with 59 illustrations. Vienna: Julius Springer, 1926.

Standard outline of German practice in urology.

THE DOCTOR LOOKS AT LOVE AND LIFE. By Joseph Collins. Cloth. Price, $3 net. Pp. 279. New York: George H. Doran Company, 1926.

Dr. Collins continues to observe and to be puritanically shocked.

INFEKTIONSKRANKHEITEN. Von K. Bingold, und Anderen. Erster Band, zweiter Teil—Handbuch der inneren Medizin. Herausgegeben von G. v. Bergmann und R. Staehelin. Second edition. Cloth. Price, 54 marks. Pp. 1515, with 171 illustrations. Berlin: Julius Springer, 1925.

ERKRANKUNGEN DER VERDAUUNGSORGANE. Von G. v. Bergmann und Anderen. Dritter Band, erster Teil—Handbuch der inneren Medizin. Herausgegeben von G. v. Bergmann und R. Staehelin. Second edition. Cloth. Pp. 1051, with 471 illustrations. Berlin: Julius Springer, 1926.

ERKRANKUNGEN DER VERDAUUNGSORGANE. Von G. v. Bergmann und Anderen. Dritter Band, zweiter Teil—Handbuch der inneren Medizin. Herausgegeben von G. v. Bergmann und R. Staehelin. Second edition. Cloth. Price, 48 marks. P. 723, with 119 illustrations. Berlin: Julius Springer, 1926.

BLUT. BEWEGUNGSAPPARAT. KONSTITUTION. STOFFWECHSEL. BLUTDRÜSEN. ERKRANKUNGEN AUS PHYSIKALISCHEN URSACHEN. VERGIFTUNGEN. Von W. Alwens und Anderen. Vierter Band, erster Teil. Handbuch der inneren Medizin. Herausgegeben von G. v. Bergmann und R. Staehelin. Second edition. Cloth. Price, 69 marks. Pp. 1033, with 126 illustrations. Berlin: Julius Springer, 1926.

ERKRANKUNGEN DES NERVENSYSTEMS. Von G. v. Bergmann und Anderen. Fünfter Band, erster Teil. Handbuch der inneren Medicine. Herausgegeben von G. v. Bergmann und R. Staehelin. Second edition. Cloth. Price, 69 marks. Pp. 1073, with 431 illustrations. Berlin: Julius Springer, 1925.

ERKRANKUNGEN DES NERVENSYSTEMS. Von G. v. Bergmann und Anderen. Fünfter Band, zweiter Teil. Handbuch der inneren Medizin. Herausgegeben von G. v. Bergmann und R. Staehelin. Second edition. Cloth. Price, 33 marks. Pp. 1605, with 112 illustrations. Berlin: Julius Springer, 1926.

ANNUAL HANDBOOK, 1926-7 OF THE BRITISH MEDICAL ASSOCIATION. Paper. Price, 3/6 net. Pp. 250. London: British Medical Association, 1926.

PROCEEDINGS OF THE ASSAM BRANCH, BRITISH MEDICAL ASSOCIATION, ANNUAL MEETING, SILCHAR, 1ST AND 2ND MARCH, 1926. Paper. Pp. 58. Calcutta: Indian Tea Association, 1926.

FORTIETH REPORT (48TH YEAR) OF THE STATE DEPARTMENT OF HEALTH OF CONNECTICUT FOR THE YEAR ENDING JUNE 30, 1925. Cloth. Pp. 405. Hartford, 1925.

Medicolegal

Charging that a White Man Has Negro Blood

(Deese v. Collins (N. C.), 133 S. E. R. 92)

The Supreme Court of North Carolina affirms a judgment dismissing the action brought by the plaintiff, a white man, to recover damages for slander by the defendant, who, he alleged, falsely and maliciously charged him with having negro blood in his veins. The plaintiff did not allege, or offer evidence tending to prove, special damages resulting from that charge; and the supreme court says that the sole question presented by this appeal was whether a false statement made by the defendant that the plaintiff had negro blood in his veins is actionable per se (in and of itself), under the law of North Carolina. If words falsely spoken of and concerning the plaintiff by the defendant charge him with an infamous offense, or with having an infectious disease, or impeach his trade or profession, such words are per se actionable, because these words necessarily tend to his degradation and injury, and the plaintiff may recover as a matter of course, without showing that he has actually sustained damages. But when the words spoken are such as do not on their face import such degradation as will of course be injurious, then the plaintiff must aver some special damages, and he must show by proof that he has in point of fact sustained a loss before he can recover. In *McDowell* v. *Bowles*, decided at the December term, 1860, and reported in 53 N. C. 184, this court held that it was not actionable per se to charge, by spoken words, that a white man was a free negro. On the authority of that case this court must hold that, under the law of North Carolina, words charging that a white man has negro blood in his veins are not actionable per se. In order to maintain an action for damages resulting from such words, the plaintiff must allege and prove special damages. The words do not impute a crime or a misdemeanor punishable by an infamous penalty; they do not impute a contagious disease by which the plaintiff will be excluded from society; nor are they derogatory to the plaintiff in respect to his trade or profession.

Discharge of Physician for Absence After Condonance

(Gordon v. Dickinson (W. Va.), 130 S. E. R. 650)

The Supreme Court of Appeals of West Virginia, in awarding a new trial after the plaintiff, a physician, had obtained a judgment for $1,501.45 damages, says that the basis of the action was the alleged breach by the defendant of his contract of employment of the plaintiff as a physician and surgeon for one year, to serve the miners employed by two coal companies, and the families of such miners, the plaintiff alleging a wrongful discharge by the defendant. The contract of employment was expressed in a formal letter, which stated that it was understood that the plaintiff was to give this work and the welfare of the employees of the two mines his whole-hearted and undivided attention, and that in the event that he had to be away from the mines he was to place a competent physician at a certain point ready to respond to any calls.

This court is impressed with the fact that the contract between the parties was a burdensome and exacting one on the part of the plaintiff, but it was most important that the men in the mines and their families should continually have a physician on hand whose services could be had at every hour in the day and night, and that was the kind of services the parties to the contract contracted for. The plaintiff understood and appreciated the nature of the contract, and regarded his duties under it as a "bitter pill" to take; but as he undertook the burdensome job, which the defendant was very careful to impress on him beforehand, it was a condition of his continuing in the service that he should comply with its terms. Yet very soon after the plaintiff entered on his duties under the contract, numerous complaints were lodged against him by employees of the coal companies, each of

whom contributed $2 a month toward his salary, their complaints being on account of his absence from his office and their inability to locate him when needed. Finally, he was notified that, on account of a recent absence during the latter part of a month, his services would cease at once.

The plaintiff rested his right of recovery, not on literal proof of compliance with his contract, but on the theory of condonance of his breaches thereof, and his willingness and ability to continue therein to the end of the term. But while knowledge of and condonance by an employer of prior acts of misconduct and negligence of an employee will not justify discharge of the latter, yet if such acts are subsequently repeated, the entire course of conduct of the employee may be taken into consideration by the employer as justification for the discharge of the employee. Condonance by an employer of prior acts of an employee amounting to a breach of contract by the latter is always with the implied condition of future good conduct in compliance with the terms of the contract. Furthermore, payment by an employer of the wages or salary of his employee to the date of the latter's discharge will not constitute a waiver by the employer of breaches of the contract or deprive him of his right to terminate the employment on account of such breaches.

Unwarranted Assignments of Error in Malpractice Case

(Parr v. Young (Kan.), 246 Pac. R 181)

The Supreme Court of Kansas, in affirming a judgment for $5,000 damages in favor of the plaintiff, says that while he was cranking the engine of a truck his wrist joint was dislocated by throwing the ulna upward and forward through the skin toward the palm of the hand, and the radius was broken. The injury was treated by the defendant, with such results that he found it necessary to break the arm again in an attempt to straighten it, which was so unsuccessful that he finally told the plaintiff to let it go five or six months and he would break it again. The jury returned the following special findings of fact:

1. Did the defendant exercise reasonable and ordinary care and diligence in the exercise of his duties as surgeon and physician in the care and treatment which he rendered to the plaintiff? A. No.

2. If you answer the foregoing question in the negative, specify the particulars wherein the defendant failed to exercise such care and diligence. A. According to the evidence as well as the result obtained, the plaintiff did not receive the care and attention due him.

Being required to return a more specific answer to the second question, the jury added:

Also due to improper adjustment of splint and general indifference shown by the defendant in postponing indefinitely after the last adjustment when his attention was called to the abnormal condition of the plaintiff's arm.

The defendant moved to strike out the answer to the second question, on the ground that it did not comply with the requirement of the question, but the motion was denied, and the supreme court upholds the ruling, being of the opinion that the completed answer fully met the requirement of the question. The plaintiff, it goes on to say, had been deprived in large degree of the use of an arm through improper splinting, a particular in which the defendant failed to exercise ordinary care and diligence, pleaded in the petition and proved by expert surgical testimony at the trial.

When the jury came in the first time, the defendant requested that, if the jury found any act of negligence, it be required to state when the act occurred—whether before or after the bones were reset. The requested additional finding was not stated in writing, as the code requires. It was entirely within the discretion of the court whether it would entertain the request after the trial was virtually concluded, and the request was properly denied.

The court instructed the jury that the fact that the plaintiff did not get as good results as he expected or hoped for was not of itself evidence that the defendant was negligent, but was only a circumstance to be considered with all the evidence in the case. The defendant contended that the answer first returned to the second question showed that the jury deliberately disregarded the instruction, and, because the jury disregarded the instruction, it was actuated by passion and prejudice. The jury disregarded the instruction to this extent only: It did not consider what the plaintiff expected or hoped. It dealt entirely with factual matters, the evidence and visible results, and on those facts reached the conclusion that the plaintiff did not receive due care and attention—an inevitable conclusion, temperately expressed.

The court instructed the jury that it was the plaintiff's duty to follow such reasonable directions and advice as the defendant gave him, and to exercise ordinary prudence in the care and use of his arm. The defendant contended that the plaintiff was guilty of contributory negligence because he did not wait six months, and then return to have his arm broken. The question was whether the plaintiff was guilty of negligence in keeping away from the defendant. The jury and the district court thought he was not, and this court is in full accord.

The court instructed the jury that, if the plaintiff's arm could have been benefited by further operation, and he intentionally deferred further treatment or operation until after his lawsuit with the defendant was tried, he could not recover for such permanent injury as the proof showed might have been corrected. Evidence was not presented in the defendant's abstract or supplemental abstract showing the extent to which the condition of the plaintiff's arm might now be remedied, or the cost to the plaintiff in money, time, system shock, and physical pain of another operation by a competent surgeon. The jury found from the evidence that the plaintiff was entitled to compensation for his injuries in the sum of $5,000. The jury could not, and this court cannot, reduce the amount without data on which to base the reduction. The court is unable to declare from the evidence that the verdict was excessive in amount.

Appointment of Physicians Pending Review of Award

(Wood v. Eagle-Picher Lead Co. (Kan.), 245 Pac. R. 1015)

The Supreme Court of Kansas, in affirming a judgment for the plaintiff under the workmen's compensation law, says that it was stated that, pending a motion to set aside the award, the defendant asked the trial court to reopen the question and take additional testimony to ascertain whether the award was excessive. But that court had before it the evidence of quite a number of physicians, including two that the arbitrator had selected, and if a request was made that still others should be called, the court in the exercise of its discretion must have determined that further testimony was unwarranted. The statute provides that the court may, on application of a party for review, appoint a physician or a surgeon or two physicians to examine the workman and report to the court, and if he finds any of the grounds exist which are within the scope of the review, he may modify the award. It may be done, but that term does not imply that it must be done on application regardless of what is disclosed by the evidence and the circumstances of the case. It is to be done only when the circumstances of the case or changed conditions convince the court that good reasons exist for such action. In other words, an application to call additional medical witnesses may be granted on a review, if the showing and circumstances brought to the attention of the court warrant it, but it is not required to be done on the mere application of a party regardless of the facts and circumstances of the case.

Society Proceedings

COMING MEETINGS

Sioux Valley Medical Association, Sioux City, Iowa, Jan. 18-19. Dr. R. F. Bellaire, Trimble Block, Sioux City, Secretary.

Society of American Bacteriologists, Philadelphia, Dec. 28-30. Dr. James M. Sherman, Cornell University, Ithaca, New York, Secretary.

Tri-States Medical Association of Mississippi, Arkansas and Tennessee, Memphis, Tenn., Feb. 1-3. Dr. A. F. Cooper, Bank of Commerce Building, Memphis, Secretary.

Current Medical Literature

AMERICAN

The Association library lends periodicals to Fellows of the Association and to individual subscribers to THE JOURNAL in America for a period of three days. No foreign journals are available prior to 1921, nor domestic prior to 1923. Periodicals published by the American Medical Association are not available for lending, but may be supplied on order. Requests should be accompanied by stamps to cover postage (6 cents if one and 12 cents if two periodicals are requested).

Titles marked with an asterisk (*) are abstracted below.

American Journal of Medical Sciences, Philadelphia

172: 469-624 (Oct.) 1926

*Problems in Renal Pathology. E. Moschcowitz, New York.—p. 469.
*Experimental Nephritis Produced by Irradiation. F. W. Hartman, A. Bolliger and H. P. Doub, Detroit.—p. 487.
*Blood Clotting. C. A. Mills, Cincinnati.—p. 501.
Influence of Various Factors on Hemagglutination of Erythrocytes. C. C. Higgins, Cleveland.—p. 510.
*Leukemoid Blood Pictures in Various Clinical Conditions. E. B. Krumbhaar, Philadelphia.—p. 519.
*Occurrence of Anemia in Four Generations. W. W. G. Maclachlan and F. M. Kline, Pittsburgh.—p. 533.
*Periodic Variability of Some Forms of Arterial Hypertension. L. H. Sigler, New York.—p. 543.
Hemoglobin Estimates in Pregnancy. W. Kerwin and L. L. Collins, St. Louis.—p. 548.
Varicose Ulcer: Associated Pain and Pupil Inequality. J. Byrne, New York.—p. 553.
*Human Gastric Response to Meat and Yeast Extracts. L. M. Gompertz and W. Cohen, New Haven, Conn.—p. 565.
Cholecystitis Associated with Situs Transversus. R. B. Bettman and H. F. Binswanger, Chicago.—p. 570.
*Hypoglycemic Coma Due to Repeated Insulin Overdosage. E. L. Sevringhaus, Madison, Wis.—p. 573.
*Ruptured Graafian Follicle or Corpus Luteum Cyst Simulating Acute Appendicitis. E. Brakeley and C. E. Farr, New York.—p. 580.
*Myxedematous Ascites Removed by Thyroid Extract. H. E. Marsh, Madison, Wis.—p. 585.
*Treatment of Hay-Fever with Ephedrine. F. W. Gaarde and C. K. Maytum, Rochester, Minn.—p. 588.
Duodenal Diverticulum; Case. R. H. Kampmeier, Ann Arbor, Mich. —p. 590.

Renal Pathology; Classification of Nephropathies.—A classification of the strictly medical nephropathies is submitted by Moschcowitz which is based partly on pathogenesis and partly on clinical facts. The use of the term "nephrosis" has no consistent pathologic substratum and is therefore merely a clinical entity. When the term is used, it should always bear a qualification as to what variety of "nephrosis" is meant. Evidence is brought forward to show the sequential relation of nephritis and arteriosclerosis to hypertension. Nephritis and arteriosclerosis are the same disease, and represent contemporaneous reactions to the same insult, namely, hypertension. The term "arteriocapillary fibrosis" is suggested to cover these pathologic reactions. There is evidence to show that acute glomerular nephritis also represents a generalized capillary disease, in which the renal lesion is the localized expression, perhaps the most predominant one. There is evidence to indicate that the hypertension is the direct result of the increased resistance due to the capillary disease, and that the sequential relation of hypertension to the nephritis is only specious.

Experimental Irradiation Nephritis.—Hartman et al. show experimentally that renal epithelium is readily injured by the high voltage roentgen ray applied through the abdominal wall with comparatively small changes in other organs. In proportion to the epithelial injury, an increase in interstitial tissue takes place which replaces most of the tubules and distorts those remaining. The blood vessels from the renal artery to the small capillaries show thickening of their walls, and many undergo complete endarteritis. The glomeruli are relatively well preserved. Albumin and casts appear in the initial stages, marked polyuria with low specific gravity in the subacute stage, and gradual depression of dye excretion with marked nitrogen retention in the final stages. Constitutional changes consisted of hypertension and macular changes. The terminal periods were characterized by acidosis, vomiting, convulsions, coma and oliguria and anuria.

Blood Clotting.—Howell's work on antithrombin is confirmed by Mills. The direct activation of prothrombin by cephalin and calcium is substantiated. The author presents a complete theory of blood clotting, involving both tissue fibrinogen and thrombin clotting.

Leukemoid Blood Pictures.—In the ten cases reported by Krumbhaar, blood pictures were found, which, from the appearance of the blood alone, would be indistinguishable from one of the various forms of leukemia. In only three was the clinical diagnosis difficult. Without better knowledge of the causes of the leukemias, however, cases associated with infection may be encountered in which definite differential diagnosis is impossible, even after necropsy has been performed. In other words, it may not be possible to distinguish between a terminal leukemoid blood picture (with bone-marrow hyperplasia and infiltration of viscera) and an acute terminal true leukemia.

Anemia in Four Generations.—In four generations of a family reported on by Maclachlan and Kline, a severe form of anemia, which has usually caused death, has been present. In all, there have been seventeen cases of anemia; thirteen patients are dead and four are living. Of the thirteen deaths, seven were due to pernicious anemia. Of the four patients living, three have been seen and undoubtedly have pernicious anemia. In the other living patient pernicious anemia has been diagnosed by a competent observer. It would appear, therefore, that there is reason to believe that the type of anemia which runs through this family has been of a very severe grade, and in all probability of the so-called pernicious or primary form. It is further interesting that there are seven instances of secondary anemia in the third and fourth generations. In one of these cases there is a very low free hydrochloric acid content in the stomach, and the blood smear showed some tendency to the formation of the large red cells.

Periodic Variability of Arterial Hypertension.—Five cases, with periodic variations in blood pressure readings ranging from marked hypertension to subnormal, are discussed by Sigler. The pathologic changes in the circulatory and renal structures, as shown by clinical manifestations, could not account for these variations, nor could such variations be accounted for by any change in the mode of living of the patients. It would seem that variations of this kind, as well as hypertension in general, are dependent on some structural or functional abnormality in the vegetative nervous system exhibiting itself in the form of vasomotor pressor effects.

Gastric Response to Meat and Yeast Extracts.—Gompertz and Cohen regard vitamin B or yeast extract as a combined tonic, succogogue and food product of undoubted clinical value. In certain pathologic conditions, when meat or its extractives are prohibited, yeast products may be substituted. Such preparations may be of especial value, for instance, in hospitals in which patients of certain religious beliefs refuse to take meat; and from this standpoint, yeast-vitamin preparations may have dietotherapeutic value in appropriate conditions.

Hypoglycemic Coma Due to Insulin Overdosage.—Hypoglycemic reactions have been observed by Sevringhaus in five persons. In each patient, the usual type of reaction had occurred at times, but following prolonged hypoglycemia or hypoglycemia repeated at intervals of a few hours, the reactions were characterized by disorientation and amnesia, with no premonition sufficient to allow of asking for help. Convulsions did not occur. The dangers in such reactions are mentioned.

Ruptured Graafian Follicle Simulating Appendicitis.—Brakeley and Farr report fifteen cases which illustrate the lack of any one distinguishing feature of cystoma of the ovary, and the difficulty of diagnosis from appendicitis, ruptured ectopic pregnancy or salpingitis.

Myxedematous Ascites Removed by Thyroid Extract.—Marsh reports a case of ascites in a woman presenting herself for the relief of progressive enlargement of the abdomen, obviously not due to cardiac disease. The appearance of this patient gave the impression of late pernicious anemia or nephritis. The basal metabolic rate was minus 37 per cent.

Following the administration of thyroid extract, the ascites disappeared and the patient recovered. Stopping treatment caused a return of the ascites.

Ephedrine for Hay-Fever.—Twenty-six patients with active hay-fever of the autumnal type were treated by Gaarde and Maytum with 60 mg. doses of ephedrine, given orally in capsules. Thirteen obtained complete or almost complete relief from symptoms for from three to seven hours after each dose. Excessive nasal secretions stopped, ocular symptoms disappeared and in every way the patients were entirely comfortable. In five cases, the result was fair, and partial relief was obtained for two or three hours after each dose. In eight cases, the results were negative; little or no benefit was received.

Journal of Bone and Joint Surgery, Boston

8: 701-912 (Oct.) 1926

Mechanism and Treatment of Backfire Fracture. H. C. Edwards, London.—p. 701.
Traction Apparatus Used in Correcting Equinus Deformities. A. E. Flagstad, St. Paul.—p. 718.
*Os Calcis Fractures: New Method of Reduction. M. C. Harding, San Diego, Calif.—p. 720.
Transplant of Upper Extremity of Fibula to Replace Upper Extremity of Humerus. R. M. Schauffler, Kansas City, Mo.—p. 723.
Bone Sarcoma. Diagnosis from Benign Lesions. J. C. Bloodgood, Baltimore.—p. 727.
Light Portable Extension Frame. W. A. Clark, Pasadena, Calif.—p. 750.
Traction in Diseases and Deformities of Joints. J. L. Porter, Chicago. —p. 753.
*Comparative Studies Between Synovial Fluid and Plasma. N. Allison, F. Fremont-Smith, M. E. Dailey and M. A. Kennard, Boston.—p. 758.
Avulsion of Lesser Trochanter. S. A. Schlueter, Cleveland.—p. 766.
Arthroplasty of Hip. W. S. Baer, Baltimore.—p. 769.
Late Results of Reconstruction Operation. A. Whitman, New York.—p. 803.
Painful Exostosis of Little Toe: Operation for Its Relief. F. Christopher, Evanston, Ill.—p. 821.
Congenital Dislocation of Knee Joint. C. H. Baldwin, Utica, N. Y.—p. 822.
*Patellae in Children. A. R. Shands, Jr., Baltimore.—p. 824.
Avulsion Fracture of Tuberosity of Ischium. H. Milch, New York. —p. 832.
*Protein Arthritis. P. B. Magnuson, Chicago.—p. 839.
Orthopedic Principles in Treatment of Chronic Arthritis. L. T. Swain, Boston.—p. 845.
Joint Disease. R. K. Ghormley, Boston.—p. 858.

Treatment of Os Calcis Fracture.—Harding says that three things must be done to effect a reduction of the fracture: The posterior end of the heel must be drawn down, so that weight will be borne on the tuberosities and not on the fracture line; the anterior end of the heel must be pushed up to restore the arch, and the broadening must be corrected. He describes his method of accomplishing this.

Composition of Synovial Fluid and Plasma.—Protein, chloride, sugar and nonprotein nitrogen have been determined by Allison et al. in plasma and pathologic synovial fluids in twenty-three instances. The protein content of the synovial fluids is less than that of the plasma. The chloride content is greater than that of the plasma. Low plasma chloride is accompanied by low chloride in the synovial fluid. The nonprotein nitrogen is approximately equally distributed between plasma and synovial fluid. In fasting patients, the sugar content of noninfected synovial fluid is usually slightly lower than that of the plasma. The hyperglycemia caused by anesthesia is accompanied by a rise in sugar content of the synovial fluid. In four instances of bacterially infected fluids the sugar content was markedly lowered, while in two cases of tuberculosis of the joint, the sugar content was moderately lowered. This is analogous to the low sugar content of the cerebrospinal fluid in purulent and tuberculous meningitis. It is suggested that determination of the sugar content of synovial fluids may prove to be of diagnostic value.

Patellae in Children.—An analysis made by Shands of 100 roentgenograms of knees of children between the ages of 2½ and 6 years shows an absence of the ossification center of the patella in thirty-two. Tuberculosis has a definite effect on the development of the ossification of the patella, rickets has a definite effect on the time of appearance of the ossification center, while congenital syphilis has no constant effect on either. In one case reported of delayed appearance of the ossification centers of the patellae, the undernutrition of the patient stands out as the most important factor. Two cases were observed with two ossification centers for the patella.

Protein Arthritis and Protein Intake.—Magnuson believes that there is a definite relation between high protein intake and chronic joint pain; this is not always indicated by high uric acid content in the blood, although it may be. There is a definite form of arthritis due to or associated with incomplete metabolism, poor elimination, or both. One of the author's patients was put on treatment which consisted of a low protein intake, eliminating purines so far as possible, with increased fluid intake, and an increase in the intestinal elimination, and, in this case, hydrochloric acid with his meals. He reported that within ten days his symptoms had entirely cleared up and they have remained cleared up, except when he returned to a high protein diet and did not maintain elimination in the way of water intake and intestinal output, at which times his symptoms recurred.

Journal of Comparative Neurology, Philadelphia

42: 1-163 (Oct. 15) 1926

Growth of Nervous System of Amphibia: VII. Growth of Pattern of Association Mechanism of Rhombencephalon and Spinal Cord of Amblystoma Punctatum. G. E. Coghill, Philadelphia.—p. 1.
Functions of Giant Nerve Fibers of Crustaceans. G. E. Johnson, Manhattan, Kan.—p. 19.
Peripheral Nervous System of Common Earthworm. W. M. Smallwood, Syracuse, N. Y.—p. 35.
Vascularity of Vagus Nuclei and of Adjacent Reticular Formation in Albino Rat. E. H. Craigie, Toronto.—p. 57.
*Muscle Tonus: IV. Rôle of Sympathetic Nervous System. S. W. Ranson and J. C. Hinsey St. Louis.—p. 69.
V. Tetanus Contracture. S. W. Ranson and A. W. Morris, St. Louis. —p. 99.
*Voluntary Motor Innervation of Facial Musculature. E. Huber and W. Hughson, Baltimore.—p. 113.

Muscle Tonus: Rôle of Sympathetic Nervous System.—The conclusion is drawn by Ranson and Hinsey that the sympathetic nervous system is not responsible for the exaggerated tonus of decerebrate rigidity, and that the exaggerated tonus caused by the injection of tetanus toxin is neither due to an action of the tetanus toxin on sympathetic endings in the muscle, nor to an action of the tetanus toxin, causing an increase in tonic discharges from the spinal cord by way of the sympathetic system.

Innervation of Facial Musculature.—Huber and Hughson assert that the whole superficial facial musculature is innervated exclusively through branches of the nervus facialis. From the results of their experiments, they conclude that the anastomoses between branches of the facialis nerve and branches of the cervical plexus and trigeminus nerve are secondary connections. If disturbances in the mimetic musculature occur, following operations involving the gasserian ganglion in man, they must be due to accessory injuries done to the facialis nerve. Such complications should, therefore, be avoided through appropriate modification of the operation.

Journal of Urology, Baltimore

16: 231-317 (Oct.) 1926

Transplantation of Kidney. C. S. Williamson, Rochester, Minn.—p. 231.
Management of Ureter Calculi. N. P. Rathbun, New York.—p. 235.
Surgical Diseases of Urinary Tract in Children. A. Hyman, New York. —p. 259.
Vulvovaginitis in Children: II. Serologic Studies. E. M. Sherman and S. L. Norton, Boston.—p. 279.
Sarcoma of Prostate: Two Cases. H. L. Kretschmer, Chicago.—p. 301.
*Calcium Chloride: Intravenous Injection in Gonorrheal Epididymitis and Rheumatism. C. O. Leff and O. M. Spencer, Washington, D. C. —p. 307.
Chronic Cavernositis Cured by Diathermy. B. C. Corbus, Chicago.—p. 313.
Pedunculated Urethral Polyp. H. M. N. Wynne, Minneapolis.—p. 315.

Calcium Chloride in Gonorrheal Epididymitis.—Clinical experience has convinced Leff and Spencer that intravenous injections of .25 cc. of a 2 per cent solution of calcium chloride favorably influence the course of gonorrheal epididymitis and rheumatism. It is indicated especially when pain, tenderness and swelling are present. No untoward effects are produced if small doses are judiciously used.

Kansas Medical Society Journal, Topeka

26: 311-344 (Oct.) 1926

Cancer of Lip. Radium Therapy. M. Trueheart, Sterling.—p. 311.
Precancerous Dermatoses. S. T. Millard and W. B. Goddard, Topeka. —p. 314.
Vitamins. G. G. Naudain, Pittsburg.—p. 319.
Tumor of Carotid Body: Case. W. F. Bowen and M. B. Miller, Topeka. —p. 321.

Minnesota Medicine, St. Paul

9: 535-602 (Oct.) 1926

Degenerative Disease and Periodic Health Examinations. C. P. Emerson, Indianapolis.—p. 535.
Fads and Quackery. M. Fishbein, Chicago.—p. 540.
Medical Profession and Press. H. R. Galt, St. Paul.—p. 545.
Energy of Light. C. H. Mayo, Rochester, Minn.—p. 549.
Angina Pectoris. F. M. Smith, Iowa City.—p. 553.
Trichinosis. T. B. Magath, Rochester, Minn.—p. 558.
Amblyopia Caused by Inhalation of Carbon Monoxide Gas. W. R. Murray, Minneapolis.—p. 561.

Nebraska State Medical Journal, Norfolk

11: 369-408 (Oct.) 1926

Etiology of Pyelitis. L. F. Egen, Hastings.—p. 369.
Diagnosis of Secondary Infections of Upper Urinary Tract. A. D. Dunn, Omaha.—p. 371.
Urologic Diagnosis. E. Davis, Omaha.—p. 374.
Secondary Infections of Upper Urinary Tract: Medical Treatment. C. Waddell, Beatrice.—p. 376.
Id.: Surgical Treatment. A. D. Munger, Lincoln.—p. 378.
Pyelitis Complicating Pregnancy. R. Luikart, Omaha.—p. 380.
Pyelitis in Children. C. Moore, Omaha.—p. 381.
Nutrition: Malnutrition: 17. Treatment of Acidosis. V. E. Levine, Omaha.—p. 384.
Toxic Adenoma of Thyroid. H. C. Pedersen, Fremont.—p. 392.
Carcinoma in Anorectal Fistula Tracts. L. E. Moon, Omaha.—p. 396.
Traumatic Rupture of Spleen in Children: Two Cases. J. Buis, Pender. —p. 398.
Treatment of Pertussis; Vaccines. H. D. Myers, Howells.—p. 399.

Philippine Journal of Science, Manila

31: 1-114 (Sept.) 1926

*Experimental Pneumonia in Monkeys. O. Schöbl and A. W. Sellards. —p. 1.
Lycids of Philippines. R. Kleine.—p. 33.

Experimental Pneumonia; Pathogenesis.—In the examination of Philippine monkeys (*Pithecus philippinensis* Geoffroy), Schöbl and Sellards found three of thirteen healthy stock animals to be carriers of typical but avirulent pneumococci. Ten of nineteen monkeys developed pneumonia after intratracheal inoculation with 1 cc. of a young broth culture of a type I pneumococcus highly virulent for mice. Experimental evidence is presented which shows that pneumonia is of bronchogenic and not hematogenic origin. The topographic distribution of experimental pneumonic lesions following intratracheal inoculation is explained by the anatomic structure of the monkey's bronchial tree and by physical laws. The pathogenesis of experimental pneumonia in monkeys is explained as primarily a bronchopneumonia and, secondarily, as an interstitial inflammation. Extensive ulceration in the terminal air passages is followed by perivascular lymphangitis which, in turn, is responsible for the interstitial pneumonia.

Public Health Journal, Toronto

17: 471-520 (Oct.) 1926

Hieronymus Fracastorius: His Works on Syphilis. W. R. Riddell, Toronto.—p. 471.
Objectives and Standards of Ventilation. C. E. A. Winslow, New Haven, Conn.—p. 487.
"Sanitary Inspection of Rural Schools." J. A. Morgan, Peterborough. —p. 496.
Past and Future of Social Hygiene. G. Bates, Toronto.—p. 499.
Sanitary Inspectors' Association of Canada. Light and Health. E. W. J. Hague, Winnipeg, Man.—p. 503.

Tennessee State Medical Association Journal, Nashville

19: 91-114 (Aug.) 1926

Pott's Fracture. D. Eve, Sr., Nashville.—p. 91.
Diagnosis of Gallbladder Disease. J. Witherspoon, Nashville.—p. 95.
Importance of Mental Examinations. W. S. Farmer, Nashville.—p. 99.
Tubal Insufflation; Diagnosis of Sterility. W. T. Black, Memphis. —p. 104.
Fracture of Patella. H. M. Cox, Nashville.—p. 108.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Ophthalmology, London

10: 465-512 (Sept.) 1926

Turberville of Salisbury. R. R. James.—p. 465.
Cases of Glioma Retinae Treated at Royal London Ophthalmic Hospital During Years 1915-1924. R. C. Davenport.—p. 474.
After Results of Corneoscleral Trephining for Glaucoma. R. C. Davenport.—p. 478.
Visibility of Nuclei of Endothelial Cells of Cornea in Man. T. H. Butler. —p. 484.
Removal of Cataract with Capsule. A. Lieskó.—p. 485.

10: 513-576 (Oct.) 1926

Ocular Circulation: Its Normal Pressure Relationships and Their Physiological Significance. W. S. Duke-Elder.—p. 513.

British Medical Journal, London

2: 719-764 (Oct. 23) 1926

Debt of Medicine to Experimental Method of Harvey. J. R. Bradford. —p. 719.
*Causes and Treatment of Uterine Hemorrhage Without Gross Physical Signs: I. B. Whitehouse.—p. 723.
Id.: II. W. F. Shaw.—p. 727.
*Good Diet and Bad One. R. McCarrison.—p. 730.
New Serum Peptone in Asthma. A. G. Auld.—p. 732.
Acute Intestinal Obstruction Due to Hydrocephalic Child. H. J. D. Smythe.—p. 733.

Uterine Hemorrhage Without Physical Signs.—Two hundred consecutive cases of functional uterine hemorrhage, with no obvious physical signs, are reviewed by Whitehouse. He concludes that menstruation is the monthly abortion of the decidua of an unfertilized ovum. The menstrual discharge is the lochia of an unfertile abortion. The premenstrual endometrium is the menstrual decidua; its development and life are dependent on the corpus luteum. Menstrual abortion is initiated by death of the unfertilized ovum and retrogression of the corpus luteum. Pathologic uterine hemorrhage falls into one of four clinical groups: (*a*) epimenorrhea, (*b*) menostaxis, (*c*) menorrhagia, (*d*) metrostaxis. Epimenorrhea is the clinical manifestation of hyperactivity of the sex complex; menostaxis is an incomplete unfertile menstrual abortion. Menorrhagia is the result of uterine insufficiency, which may be (*a*) developmental, (*b*) inflammatory or (*c*) degenerative. The insufficiency may be associated with lesions in (1) the metrium; or (2) the endometrium. Metrostaxis is commonly the reflection of outside influences on the uterus. The accessory factors most frequently associated with irregular uterine bleeding are (1) functional hyperthyroidism, and (2) hypersensibility of the sympathetic nervous system. Estimation of the blood tolerance of sugar and of the basal metabolic rate is said to provide important data in the investigation of uterine hemorrhage at periods of unstable equilibrium, especially puberty and the menopause.

Good Diet and Bad One: Effects.—An experiment made by McCarrison demonstrates that a diet composed of whole wheat, milk, milk products, sprouted legumes, uncooked vegetables and fruit, with fresh meat occasionally, far surpasses in nutritive value that composed of white bread, tea, sugar, margarine, jam, boiled vegetables, and tinned meat, to which the common food preservatives—boric acid, formaldehyde vapor, and sulphurous acid—are added. The former promotes physical efficiency and health, but the latter give rise to stunting of growth, to physical inefficiency and often to disease. The maladies to which the poor diet may give rise are lung disease and gastro-intestinal disease. The results of this experiment furnished additional proof of this influence, and suggested also that the common food preservatives may contribute their share to the harmful effects of such a food.

China Medical Journal, Shanghai

40: 821-936 (Sept.) 1926

*Serofibrinous Pleurisy of Tuberculous or Obscure Origin. J. H. Korns. —p. 821.
*Ring Test for Tuberculosis. K. B. Liu and J. H. Foster.—p. 828.
Neuropsychiatry in China. J. L. McCartney.—p. 831.
Severe Bismuth Poisoning, Successfully Treated with Sodium Thiosulphate. L. F. Heimburger.—p. 842.

Acute and Chronic Myeloid Leukemia: Two Cases. C. F. Jordan.—p. 845.
Advantages of Organic Preparations of Antimony in Treatment of Kala-Azar. E. B. Struthers.—p. 849.
Cholera Sicca. A. H. Skinner.—p. 850.

Serofibrinous Pleurisy of Tuberculosis.—Of 123 cases of so-called idiopathic serofibrinous pleurisy studied by Korns, 37.7 per cent were shown by guinea-pig inoculation of the pleural fluid to have been tuberculous cases. The discharge diagnosis, based on clinical data, included pulmonary tuberculosis in ninety-five cases, or 77.2 per cent. In a series of thirteen of these cases, observed for a period of from twelve to sixty-six months, eleven, or 84.6 per cent, were considered as tuberculous cases. It was noted in the latter series that those patients who rested most completely and longest have done well, whereas, conversely, those who paid little attention to rest are now showing signs of active pulmonary tuberculosis. The conclusion, therefore, seems justified that serofibrinous pleurisy of obscure origin, after proper means have been used to exclude other causes, should be considered as a manifestation of tuberculosis and should be treated as such.

Ring Test for Tuberculosis.—The ring test for tuberculosis was made by Liu and Foster in 705 cases. This test consists in covering serum from a tuberculous patient with a dilute solution of thymol, phenol (carbolic acid), tricresol or toluene. If the test is positive, a cloud forms at the junction of the two surfaces. Of the entire series of 705 cases examined, 483 were negative and 222 positive. Of the negative patients, 466 had no signs of tuberculosis, but seventeen were definitely tuberculous. There were only 4 per cent false negatives. Of the 222 positive cases, only 104 showed tuberculosis in some form while in 118 cases, tuberculosis could not be demonstrated. There were 54 per cent false positives. The reagent used by the authors was a 0.2 per cent solution of tricresol in physiologic sodium chloride solution.

Irish Journal of Medical Science, Dublin

6: 569-616 (Oct.) 1926

Teaching of Anatomy. G. E. Smith.—p. 574.
Teaching of Physiology. J. M. O'Connor.—p. 576.
Teaching of Pathology. A. Stokes.—p. 578.
Teaching of Bacteriology. W. D. O'Kelly.—p. 581.
Teaching of Materia Medica and Therapeutics. R. J. Rowlette.—p. 583.
Teaching of Clinical Medicine. T. G. Moorhead.—p. 585.
Teaching of Surgery. D. P. D. Wilkie.—p. 590.
Teaching of Midwifery in Sweden. E. Möller.—p. 594.
Education of Gynecologist. J. L. Faure.—p. 598.
Teaching of Pediatrics. D. Paterson.—p. 601.
Teaching of Radiology. M. R. J. Hayes.—p. 603.
Teaching of Ophthalmology. C. Goulden.—p. 605.
Eighteenth Century Examination for "Mastership of Chirurgery." P. Jeunhomme.—p. 609.

Journal of Tropical Medicine and Hygiene, London

29: 343-358 (Oct. 15) 1926

*Pathology of Central Nervous System in Malignant Tertian Malaria. J. G. Thomson and S. Annecke.—p. 343.
Gongylonema of Cattle: II. H. A. Baylis, A. L. Sheather and W. H. Andrews.—p. 346.
Yellow Fever Control in West Africa. W. H. Hoffman.—p. 349.

Central Nervous System in Malaria.—The mental manifestations and general nervous symptoms of acute and chronic malaria have received a considerable amount of clinical attention, and while numerous pathologic studies have been made, Thomson and Annecke feel that it cannot, in most instances, be said that these have been correlated with the clinical observations noted before death. Although the severe pathologic conditions associated with coma due to *Plasmodium falciparum* can produce the protean clinical symptoms encountered, many suggestions have been put forward to explain them. As a general rule, almost all of the symptoms associated with acute pernicious malaria quickly respond to treatment, but it would seem that those mental and nervous symptoms of a more chronic character, attributed to previous malaria, require further study by careful clinical observation, correlated with the malarial history. Various degrees of mental impairment, such as depression, or loss of memory of varying degrees, might conceivably result from the grosser lesions present.

Bruxelles-Médical, Brussels

6: 1461-1492 (Oct. 3) 1926

Industrial and Domestic Accidents from Electricity. A. Zimmern.—p. 1461.
Struggle Against Tuberculosis in Alsace-Lorraine. Rulot.—p. 1471.
*Physiologic Manner of Suckling. P. Robin.—p. 1473.

Defective Manner of Suckling as Factor of Glossoptosis.—Robin blames the defective manner in which the breast or milk bottle is given to infants for downward displacement of the tongue and backward displacement of the lower jaw bone. Infants thus affected breathe through the mouth and snore during sleep. They swallow with difficulty and choke frequently unless turned on the abdomen. The glossoptosis is accompanied by aerophagy and vomiting after each feeding; constipation and predisposition to skin diseases are present. The infants are undersized and frequently develop rickets, spasmophilia or marasmus. When milk is given to infants lying on the back, a part, mixed with mucus, may run toward the eustachian tube and possibly cause otitis. For the baby to be suckled in the physiologic manner, its thorax must be upright and its neck extended, the chin moving forward with each act of sucking. He observed great improvement in infants with glossoptosis after three months of this method of suckling. The gums met, respiration by the nose was restored, vomiting and constipation subsided, and growth and general condition became normal.

Bulletins de la Société Médicale des Hôpitaux, Paris

50: 1507-1531 (Oct. 29) 1926

Note on Prelocomotion. Variot.—p. 1507.
*Polyadenomatosis of Large Intestine. H. Grennet and J. Delarue.—p. 1508.
Tuberculous Splenomegaly with Fibrous Degeneration. J. Tapie.—p. 1510.
Congenital Limitation of Extension of Elbow. A. Léri.—p. 1515.
*Relapse of Pulmonary Gangrene After Seventeen Years. J. Haguenau and Gilbert-Dreyfus.—p. 1521.
Early Meningeal Hemorrhage in General Paralysis. R. Targowla.—p. 1525.

Case of Multiple Adenomas of Large Intestine.—The patient in Grennet and Delarue's case, a girl, aged 14, had two attacks with a dysenteriform syndrome in the course of intestinal adenomatosis. The attacks occurred eleven months apart, each coinciding with parotitis. The patient had not had any intestinal disturbance in the past which could be accounted an etiologic factor. It is possible that the local parotid infection unleashed a latent or torpid polyadenomatosis. The clinical course, also the inflammatory lesions and partial sloughing of the adenomas found on necropsy, tend to confirm this theory. The ampulla of the rectum was intact.

Fatal Relapse of Pulmonary Gangrene After Seventeen Years.—Haguenau and Gilbert-Dreyfus treated a patient with localized gangrene of the lower lobe of the left lung, ending in death after two months. The history revealed that the patient, a woman, aged 46, had suffered from this condition seventeen years before. The functional symptoms and the localization of the lesions were then exactly the same as now. At the end of four months she had appeared clinically cured. Her general condition had been satisfactory during the entire interval between the attacks, except for ordinary bronchitis in the winter. The second attack of gangrene is considered not as a recurrence but as a relapse. It is assumed that the apparent recovery was only a phase of latent microbism, the anaerobic micro-organisms remaining in the primary focus.

Comptes Rendus de la Société de Biologie, Paris

95: 941-1012 (Oct. 22) 1926. Partial Index

*Streptococcus Antivirus in Local Immunization. L. Rossi.—p. 943.
*Immunization by Intraspinal Route. S. Mutermilch.—p. 945.
Head Grafting in Insects. J. Rostand.—p. 948.
Bactericidal Property of Human Serum. A. Georgevitch.—p. 954.
Technic for Cultivation of Tissues and Cancer Cells. A. Borrel.—p. 964.
*Electivity of Favus Fungus for the Skin. Brocq-Rousseu et al.—p. 966.
*Aggravation of Cancer from Gentian Violet. N. Dobrovolskaia-Zavadskaia and Samssonow.—p. 974.
*Action of Iodine on Rat's Testes. A. Kostitch and A. Telebakovitch.—p. 986.
*Influence of Gelatin on Production of Diphtheria Toxin. A. Godoy.—p. 998.

Streptococcus Antivirus in Local Immunization Against Streptococcus Infection.—The shaved skin of guinea-pigs was rubbed with Besredka's streptococcus antivirus incorporated in hydrous wool fat. The animals were then inoculated with streptococcus culture. They did not develop any reaction. The acquired immunity, Rossi says, was brief. It was strictly specific and local, occurring without participation of antibodies.

Active Immunization by Intraspinal Route.—Rabbits were given intraspinal injections of sheep's red blood corpuscles. This was followed by the appearance of hemolysins in the cerebrospinal fluid and in the blood stream. Further research testified to local production of antibodies in the fluid, and not to the passage of hemolysins from the blood through the meninges injured by the puncture. Mutermilch intends to try the method in tetanus, cerebrospinal meningitis, etc.

Electivity of Favus Fungus for the Skin.—Cultures of favus fungus were introduced into guinea-pigs by the vein, by the mouth, by the peritoneum or subcutaneously. Thereupon, superficial incisions were made in the skin of the animals. All developed characteristic lesions of favus, located exclusively on the scarifications.

Aggravation of Cancer by Gentian Violet.—Dobrovolskaïa-Zavadskaïa and Samssonow found that if a sarcoma implant was previously treated with gentian violet, the tumor, when implanted into mice, developed more rapidly and was accompanied by metastases.

Action of Iodine on Rat's Testis.—White rats were given an iodine preparation with food. Changes in the testes were observed, consisting first in intensive desquamation of the seminal epithelium; later in vacuolar degeneration of the spermatids, spermatocytes and spermatogonia. The local disturbances, Kostitch and Telebakovitch add, did not affect the general condition of the animals.

Influence of Gelatin on Diphtheria Toxin.—Godoy noted that the titer of diphtheria toxin is notably enhanced if the bacilli are cultivated in veal bouillon instead of beef bouillon. This is due to a larger content of gelatinoid substances in the former. When 5 per cent of gelatin was added to beef bouillon as much toxin was obtained as when veal bouillon was used.

Médecine, Paris

7: 869-944 (Sept.) 1926

Biologic Movement in 1926. J. Gautrelet.—p. 869.
International Congress of Physiologists in Stockholm. Tiffeneau.—p. 877.
Epinephrine and Heart Complications from Chloroform. E. Bardier and A. Stillmunkès.—p. 889.
Basal Azoturia and Azotemia in Man. C. Richet, Jr.—p. 896.
Peak Metabolism. J. Ginja.—p. 905.
*Internal Medium of the Organism. Mestrezat.—p. 911.
Conditional Rhythmic Reflexes. Zeliony.—p. 914.
Manometric Measurement of Permeability of Upper Respiratory Tract. J. Beyne.—p. 919.
Vegetative System and Pregnancy. H. Vignes.—p. 924.
Influence of Certain Factors on the Poisoning of Fishes. E. Bachrach.—p. 932.

Capillary Lymph as True Internal Medium of the Organism.—Mestrezat points out that the transudate of the capillaries or the capillary lymph is the internal medium of the organism. It penetrates into the innermost tissues, carrying nutritive elements to the cells, and taking away from them material destined for elimination. He finds that the capillary lymph is a hyaline, colloid-free fluid, identical with the cerebrospinal fluid. After taking up the excretory products of the cells, the original capillary lymph becomes an albuminous, coagulable and toxic fluid. This is the lymph of the thoracic duct. The subarachnoid spaces are nothing else than lymphatic spaces.

Presse Médicale, Paris

34: 1393-1408 (Nov. 6) 1926

"Atrioventricular" Rhythm. E. Géraudel.—p. 1393.
*Hemolytic Jaundice from Anaphylactic Shock. J. Le Calvé.—p. 1395.
Pseudorabies in Man. D. Jonnesco.—p. 1397.
Surgical Treatment of Cirrhotic Ascites. V. V. Krestovsky.—p. 1398.

34: 1409-1424 (Nov. 10) 1926

Intra-Uterine Transmission of Tuberculous Virus. A. Calmette et al.—p. 1409. Summarized in our Paris letter, Dec. 11, p. 2011.
Sexual Indifference in Schizomania. R. Dupouy and G. Naudascher.—p. 1409.
Azotemia in Surgery. A. Crainicianu and J. Florian.—p. 1411.
Rôle of Traumatism in Arteritis Obliterans. P. P. Ravault and J. de Girardier.—p. 1413.

Hemolytic Jaundice from Anaphylactic Shock.—In Le Calvé's patient, a young woman with typhoid history, gastro-intestinal disturbances first occurred after ingestion of spoiled fish. There were paroxysms of abdominal pain as from irritation of the abdominal sympathetic. Jaundice soon followed and was always aggravated during these paroxysms. The urine contained urobilin but not bilirubin. Clinical examination and the blood picture suggested the diagnosis of hemolytic jaundice with presence of autolysins. Disequilibrium of the vagosympathetic system and abnormally high sensitiveness to proteins (milk) pointed to the anaphylactic origin of the disease. The patient refused to keep to an appropriate diet and hemoclastic crises were consequently frequent, rendering regeneration of the blood impossible. The woman died two years later.

Boletín del Instituto de Med. Exper. Buenos Aires

2: 487-770 (July) 1926

*Cancer Mortality in Buenos Aires. A. H. Roffo and J. Bisi.—p. 487.
*Irradiation of Neoplastic Cells Cultivated in Vitro. A. H. Roffo.—p. 541.
Hypercholesteremia in Precancerous Conditions. A. H. Roffo.—p. 559.
Cholesterol-Producing Properties of Normal and Neoplastic Tissues. A. H. Roffo and C. Griot.—p. 584.
Electric Charges of Blood Cells. A. H. Roffo and H. De Giorgi.—p. 591.
Activity of Catalase in Normal and Neoplastic Tissues. A. H. Roffo and B. Barbará.—p. 599.
Neoplastic Cultures in the Spleen. A. H. Roffo and A. Encina.—p. 607.
Cholesterol and Tissue Growth. A. H. Roffo and I. Azaretti.—p. 629.
Laryngeal Angiomas. J. Basavilbaso and J. Bianculli.—p. 634.
Technic of Neutral Red Test. A. H. Roffo.—p. 640.
Generalized Idiopathic Sarcomatosis of the Skin. M. Aberastury.—p. 641.
Fabre's Method for Extracting Alkaloids. L. Rossi and R. Lobo.—p. 699.

Cancer in Argentina.—Roffo publishes detailed statistics of the death rate from cancer in Buenos Aires from 1884 to 1925. The curve fluctuates from 46.53 per hundred thousand in 1884 to 143.64 in 1887, 56.29 in 1890, 100.62 in 1903 and 112.70 in 1925. As elsewhere, mortality reaches its maximum between the ages of 50 and 60. Men are affected about one and one-half times as often as women. External cancer apparently tends to decrease and cancer of the digestive organs to increase. Cancer mortality is about twice as large among foreigners as among natives. It also seems to be higher in the more prosperous districts.

Action of Roentgen Rays on Cancer Cells.—A number of experiments by Roffo failed to show any effect from roentgen rays on cancer cells in vitro. In many cases doses as high as 200 kilowatts were used, both with and without screens, for an hour and a half.

Boletín de la Soc. de Obstet. y Ginec., Buenos Aires

5: 335-368 (Oct. 4) 1926

*The Cervix in the Pathogenesis of Sterility. E. A. Fox.—p. 335.
*Uterine Origin of Ovarian Cancer. A. J. Bengolea and A. J. Pavlovsky.—p. 348.
Twin Pregnancy with Degenerated Hydatidiform Mole. S. E. Bermann.—p. 364.

The Cervix as a Cause of Sterility.—Sterility caused by changes in the cervix is relative, not absolute, and can be cured surgically. The two methods most in favor, states Fox, are Martin's and Pozzi's. Bazterrica has simplified Pozzi's technic, and Iribarne's tip also helps in stenosis. Fox has used the two operations on over forty patients and knows of seven subsequent pregnancies. Before resorting to surgery, it is advisable to await the result of a few years of married life. Boero held that in these cases the physician should always hold out some hope. In some cases of genital hypoplasia in which sterility had been labeled as incurable, children have later been born. In men also the physician should be very cautious as to diagnosing impotence, as complications may arise if the wife afterward becomes pregnant. Nicholson

asserted that men submit more readily to examination if the difference between impotence and sterility is explained.

Uterine Origin of Ovarian Cancer.—In a case of malignant growth in the left ovary, reported by Bengolea and Pavlovsky, the uterus was removed to get a better approach. Microscopic examination of the uterine tissue showed malignant degeneration of the mucous membrane. There were also metastases in both ovaries and enlargement of glands. Many alleged primary ovarian tumors are probably secondary to malignant growths of the uterus.

Brazil-Medico, Rio de Janeiro

2: 233-244 (Oct. 23) 1926

*Sodokosis or Sodoku? A. da Matta.—p. 233.
Production of Specific Antibodies by Injections of Whole Extract of Cysticercus Cellulosae. S. B. Pessôa et al.—p. 235.

Sodokosis, Not Sodoku.—In describing two cases of rat-bite fever, da Matta comments on the present designation of the disease in several languages. Both the English and the German names entail some confusion. Sodoku is incorrect, as it only means poisonous bite by a rat. Sodokosis or rat bite spirochetosis would be more appropriate.

Hospital General, Mexico City

1: 329-476 (July-Sept.) 1926

*Sexual Impotence and Verumontanitis. F. Quiroz G.—p. 329.
Bronchopneumonic Lesions in Influenza. E. Ulrich.—p. 336.
Abnormality in Human Ovum. E. Landa.—p. 347.
*Mercurochrome in Puerperal Fever. R. Escobar.—p. 353.
*Mercurochrome in Leprosy. S. Villalobos.—p. 358.
Pathologic Changes in Pellagra. S. González H.—p. 367.
*Electrolysis in Otitis Media. V. Manero.—p. 369.
Bilateral Spinal Embryotomy. J. Rábago.—p. 372.
Total Splenectomy. F. Aceves.—p. 378.

Inflammation of the Verumontanum as a Cause of Sexual Impotence.—Quiroz states that in a number of cases, sometimes as high as 80 per cent, of male impotence the cause may be found in lesions of the verumontanum. In twenty-three cases treated within the last four years, the patient connected the loss of erectility with previous venereal disease. Examination usually disclosed involvement of the verumontanum. Several typical histories are given. In practically all the cases followed, the management proved successful. In acute cases of mere swelling or inflammation, the high frequency current was used; in chronic cases, the electrocautery and fulguration were employed.

Success of Mercurochrome in Erysipelatous Puerperal Fever.—In the treatment of puerperal fever, a marked difference was noted by Escobar in the effect of mercurochrome. Thus, in fourteen cases complicated with erysipelas there was only one failure, although other treatments had previously failed. In some cases only three injections at four day intervals were needed. On the other hand, when the infection was localized in the adnexa, the drug, even in larger doses, did not influence either the fever or the course of the disease. While both groups were clearly streptococcic, one was caused by hemolytic strains and the other by anhemolytic types. Mercurochrome apparently con do nothing in the former variety.

Failure of Mercurochrome in Leprosy.—Villalobos tried 1 per cent mercurochrome in twenty-six lepers. As many as ten intravenous injections were given, starting with 2 cc. and increasing to 5 or 6 cc. The drug proved harmful rather than otherwise, inducing symptoms of intoxication in a number of cases. It seemed to act favorably, however, on syphilitic complications and also as a local antiseptic, when combined with chaulmoogra ointment. Lack of occupation affects the morale of lepers unfavorably, and some kind of manual work, preferably farming, should always be furnished.

Electrolysis in Suppurative Middle-Ear Infections.—In a number of cases of chronic middle-ear infection, some subsequent to mastoid operation, the usual medical treatment failed to bring improvement. Manero then decided to try weekly applications of electrolysis. Out of nineteen patients (four with bilateral infection), 34 per cent were cured and 11 per cent improved temporarily.

Semana Médica, Buenos Aires

33: 905-976 (Oct. 7) 1926

Sanocrysin in Pulmonary Tuberculosis. E. M. Fernández Rey et al.—p. 905.
Endothelioma of Diaphragmatic and Mediastinal Pleura. P. Escudero and J. W. Tobías.—p. 932.
Fetal Hydrocephalus in Successive Pregnancies. D. Iraeta and E. Harguindeguy.—p. 934.
Early Radiographic Diagnosis of Pregnancy. A. Peralta Ramos et al.—p. 937.
Kahn's Test for Syphilis. J. W. Howard.—p. 940.
*Berberin in Treatment of Malaria. H. Quintana and N. Alvarez Soto.—p. 943.
Treatment and Prevention of Syphilis in Maternity Hospitals. A. Peralta Ramos and M. L. Pérez.—p. 945.
Bradyphrenic Dementia After Encephalitis. G. Bermann and A. Barrancos.—p. 951.
Aberastury's Life Work. P. Escudero.—p. 958.
Sanocrysin in Pleuropulmonary Tuberculosis. R. E. Torviso.—p. 959.

Berberin in Malaria.—Fourteen years' experience with berberin and its salts has shown Quintana and Alvarez Soto the value of this drug together with quinine. It is especially useful in enlargement of the spleen. Berberin may be given in wafers or in water with quinine and iron.

Archiv für Kinderheilkunde, Stuttgart

79: 81-160 (Sept. 17) 1926

*Contagiousness of Tuberculosis. K. Ossoinig.—p. 81.
*Atropine in Childhood. F. Ritte.—p. 89.
Dosage of Diphtheria Antiserum. J. Widowitz.—p. 101.
"Pathogenesis of Pyuria in Infants." E. Schiff.—p. 105.
Effect of Ultraviolet Rays on the Food and the Organism of the Child. H. Koeppe.—p. 109.
Metabolism in Infants. J. Ellinghaus et al.—p. 131.
*Effect of Irradiated Oil on Metabolism. C. Brahm and I. Mende.—p. 138.

Contagiousness of Tuberculosis.—Ossoinig reports the cases of three children who had been in contact for various lengths of time with persons with tubercle bacilli in the sputum. Only one of the children, a boy, aged 10, became infected; he had been in contact with tuberculosis for from five to seven weeks. An infant was exposed to tuberculous contagion from the fourth to the eleventh month of life and a girl, aged 5, for ten hours, without developing infection. Decreased susceptibility to tuberculous contagion in infants may depend on the fact that during the first months of life they breathe through the nose.

Atropine Studies.—Ritte administered atropine subcutaneously and by mouth to a large number of infants and children and found that the individual reactions differed widely. The effect of the dose varied also in the same child. The dose must be based on the body weight. To obtain the maximal effect, he gives the atropine two hours before a meal, since its action is strongest about two hours after administration.

Effect of Irradiated Oils on the Metabolism of Infants.—Brahm and Mende administered olive oil, irradiated with ultraviolet rays, to rachitic infants and noted a positive balance of potassium, magnesium, phosphoric acid and nitrogen. Clinical observations confirmed the chemical examinations, although it was impossible to obtain healing.

Archiv für path. Anatomie und Physiologie, Berlin

261: 315-648 (Sept. 14) 1926

Primary Multiple Malignant Tumors. D. M. Chajutin.—p. 315.
Primary Carcinoma of the Liver. H. Rosenbusch.—p. 326.
Familial Teratoma. F. Lucksch and J. Ringelhan.—p. 372.
Carcinomas of Small Size. S. Derischanoff.—p. 384.
*Aging and Dying. A. Pütter.—p. 393.
Histology of Experimental Ovariotestis. H. E. V. Voss.—p. 425.
Oxidizing Substances in the Animal Cell. W. Loele.—p. 484.
"Superficial Form" of Primary Actinomycosis of the Lung. M. S. Skworzoff.—p. 503.
Histopathology of "Lecithinoid" Degeneration. T. v. Lehoczky.—p. 516.
*Blood Platelets. G. O. Roskin and F. T. Grünbaum.—p. 528.
Micromyeloblastic Leukemia. G. Seemann.—p. 533.
Elasticity, Contractility and Volume of the Human Aorta. M. I. Hwiliwitzkaja.—p. 543.
Sclerosis of Portal Vein After Appendicitis. T. Vité.—p. 565.
Echinococcus of the Heart. A. N. Dobrotin.—p. 575.
Origin of Fragmentation of Myocardium. H. Willer.—p. 586.
Pluriglandular Insufficiency. Held.—p. 600.
Differentiation of Fat in Histologic Methods. C. Kaufmann and R. Lehmann.—p. 623.

Aging and Dying.—From statistics in the literature, Pütter develops a mathematical formula and plots several curves for calculation and illustration of viability, mortality and aging of bacteria, plaice, herring, *Drosophila*, *Proales decipiens* and human beings.

Blood Platelets.—In experiments on mice, Roskin and Grünbaum used the Feulgen test for nucleoproteins for the study of blood platelets conglutinated with trypanosomes. The reaction was negative in every case, and the authors do not believe that the platelets are partially composed of leukocytic nuclei, as Komocki asserted. They consider the presence of oxydase in the blood platelets as doubtful.

Biochemische Zeitschrift, Berlin

177: 1-248 (Oct. 7) 1926. Partial Index

*Neoglucose. K. Iwasaki.—p. 10.
The Blood Sugar Problem. H. K. Barrenscheen and A. Eisler.—p. 27.
*Idem. H. K. Barrenscheen et al.—pp. 39, 50, 67 and 76.
*Idem. H. K. Barrenscheen and R. Berger.—p. 81.
Photoactivity. N. Henning and W. Schaefer.—p. 109.
Breast Milk in Beriberi. B. Matsumoto.—p. 118.
Parenteral Administration of Cadmium. G. Hessel.—p. 146.
Nutritional Value of Synthetic Fat. J. Ozaki.—p. 156.
Dietetics: Wheat. L. Berczeller and H. Wastl.—pp. 168, 181 and 190.
*Activation of Insulin. E. Glaser and G. Halpern.—p. 196.
*Globulin and the Wassermann Reaction. J. Forssman.—p. 243.

Neoglucose.—Iwasaki was not able to confirm Lundsgaards and Holbølls observation that "neoglucose" is formed under the combined action of insulin and muscle tissue on dextrose.

Effect of Dextrose on Sugar and Phosphorus in the Blood.—Barrenscheen, Doleschall and Popper noted an increase in the inorganic phosphorus in the blood during the first fifteen minutes after peroral administration of dextrose. The excretion of phosphoric acid in the urine decreased. At the end of the experiment the increase of phosphorus was greater in the venous than in the arterial blood. The blood sugar mostly returned to normal one hour after intravenous injection of 30 Gm. of dextrose. The inorganic and total phosphorus in the blood and the excretion of phosphoric acid in the urine were decreased.

Effect of Insulin on Sugar and Phosphorus in the Blood.—Subcutaneous injection of insulin did not influence the inorganic phosphorus curve in Barrenscheen and Berger's experiments on fasting individuals, although the blood sugar was considerably reduced. Previous injections of insulin did not essentially change the type of curve in alimentary hyperglycemia.

Activation of Insulin.—Glaser and Halpern found that oxydase from the eosinophilic blood granules, kinase from the small intestine and filtrates from compressed yeast had a marked activating effect on insulin.

Wassermann Reaction and Globulin.—Forssman studied the Wassermann reaction in the blood and the cerebrospinal fluid in relation to the globulin content. He concludes that the globulin is of no importance in the outcome of the reaction.

Deutsche medizinische Wochenschrift, Berlin

52: 1671-1712 (Oct. 1) 1926

The New German Pharmacopea. E. Rost.—p. 1671.
*Ulcerous Colitis. I. Boas.—p. 1674.
Tuberculous Skin Tumors. W. Richter.—p. 1675.
*Serologic Alcohol Extract Reaction. Lüttge and von Mertz.—p. 1677.
Dietotherapy of Diabetes in Children. A. Heimann-Trosien and H. Hirsch-Kauffmann.—p. 1678.
*Antitoxic Serums. A. Wolff-Eisner and J. Jahr. —p. 1680. C'en.
*Utilization of Food Rich in Cellulose. C. S. Engel.—p. 1682.
Ovarian Hormones. W. Braun.—p. 1684.
Nomenclature of Sex Hormones. S. Loewe.—p. 1685.
Fractures Slow in Healing. G. Axhausen.—p. 1686.
Treatment of Roentgen-Ray Ulcers. E. Sonntag.—p. 1687.
Two Practical Dressings. C. B. Strauch.—p. 1689.
Pharmacology of Local Anesthesia. M. Kochmann.—p. 1690.
Treatment of Skin and Venereal Diseases. F. Dietel.—p. 1692.
International Sanitary Conference at Paris. R. Otto.—p. 1694.
Schönlein in Zurich. A. Martin.—p. 1696.
Alleged Vaccinia Encephalitis. W. F. Winkler.—p. 1707.

Ulcerous Colitis.—Boas does not regard every ulcerous colitis as grave. With the spastic and constipating type a concentrated food poor in waste products, liquid petrolatum and atropine are helpful. Conservative treatment fails in grave diarrheic cases. Even large doses of opium are of no avail. Cecal fistula seems to be the only help, although the results are not always perfect: it must not be closed before one year of perfect health has elapsed. The fistula could be closed in only two of his twelve cases.

Serologic Alcohol Extract Reaction.—Lüttge and Mertz publish their complicated method of preparation and standardization of extracts for serodiagnosis of pregnancy, cancer and sex. The protein of the extract is not specific: a cancer extract may be prepared from a placenta. Only the relation of the protein to the acidity and salt content seems to matter. Syphilis, administration of drugs (including anesthetics) and inflammations are important sources of error in the test.

Antitoxic Serums.—Wolff-Eisner and Jahr desire a strict differentiation between toxins and endotoxins, but point out that the demonstration of apparent exotoxins does not establish their character as toxins. The use of bactericidal serums is limited by the amount of the endotoxin freed by them, since it may reach the lethal dose. They emphasize that very little is known about the action of antitoxic serums. A neutralization of toxin that had been produced before the injection is very doubtful. They believe that the rapidity of action of diphtheria antitoxin is due to a nonspecific protein shock. Protein treatment is successful only in infections which may be cured by focal reactions.

Utilization of Food Rich in Cellulose.—Engel calls attention to the advantages of cooking pea flour in oil after moistening it with water. The cellulose compartments are ruptured by the water vapors. The food is palatable, easily digestible and inexpensive.

Zentralblatt für Gynäkologie, Leipzig

50: 2353-2416 (Sept. 11) 1926

Cessation of Ovarian Function After Roentgen Ray Castration. R. Cordua.—p. 2354.
Lactic Acid Content of the Blood During Pregnancy. H. Kienlin.—p. 2358.
Recurrent Multiple Fibromas of the Abdominal Cavity. M. Sichel.—p. 2363.
Lesion of Sacroiliac Joint Developing in the Puerperium. A. v. Fekete.—p. 2370.
Preventing Compression of Prolapsed Umbilical Cord. J. M. Ruiz-Contreras.—p. 2377.
Pregnancy After Implantation of a Tube in the Uterus. A. Mandelstamm.—p. 2378.
Blood Corpuscle Sedimentation Speed and Mud Baths. N. Cukor.—p. 2380.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

70: 1623-1738 (Oct. 9) 1926

*"Tuberculous Spondylitis." R. J. Harrenstein.—p. 1624.
Ileus of the Small Intestine. R. Brummelkamp and A. H. Vonk.—p. 1630.
Psychiatric and Neurologic Notes from a Municipal Hospital. C. T. van Valkenburg.—p. 1637.
Repair of Perineal Tear Under Local Anesthesia. H. Boshouwers.—p. 1648.
Administration of Insulin by Mouth. M. Elzas.—p. 1650.
Parasystoles. F. S. P. van Buchem.—p. 1652.

"Tuberculous Spondylitis."—Harrenstein reports the case of a boy, aged 5, whose symptoms were stiffness of the spine and pain in the stomach during exercise. The internal organs of the patient were normal. The left knee reflex was more pronounced than the right. The Pirquet, Mantoux, Wassermann and Sachs-Georgi reactions were all negative. There had never been tuberculosis in the family. The physical examination and the roentgenogram revealed a gibbus of the tenth dorsal vertebra. A plaster corset was applied and three months later the pain and stiffness had disappeared, although the roentgenogram still showed changes in the spine. The temperature during the whole period was subfebrile. In a second case, the child, aged 5, presented similar symptoms. The temperature was normal; the Pirquet, Mantoux and Wassermann reactions were negative. There was a painful gibbus of the eleventh dorsal vertebra. The disease was treated as a tuberculous spondylitis, with the patient reclining in a plaster splint. Trauma was not present in the history in either case. The author expresses the opinion that these cases were not true tuberculous spondylitis, but anomalies of osteogenesis.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JULY-DECEMBER 1926

Abstracts of important articles in the following journals have been made in the Current Literature Department of THE JOURNAL during the past six months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Two journals may be borrowed at a time. No foreign journals are available prior to 1922, nor domestic journals prior to 1923. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Thus most of these journals are accessible to the general practitioner.

Acta Chirurgica Scandinavica. Irreg. 20 Swedish crowns. Stockholm.
Acta Medica Scandinavica. Irreg. $5.50 per vol. Stockholm.
Acta Obstetrica et Gynecologica Scandinavica. Irreg. $6. Stockholm.
Acta Paediatrica. Irreg. $5 per vol. Stockholm.
Acta Path. et Microbiol. Scand. Irreg. $6 per vol. Copenhagen.
Acta Psychiat. et Neurol. Irreg. $7 per vol. Copenhagen.
Acta Scholae Medicin. Univ. Imp. in Kioto. Irreg. 3.30 yen per issue. Tokyo.
Acta Tuberculosea Scandinavica. Irreg. $6 per vol. Copenhagen.
American Heart Journal. Bi-m. $7.50. St. Louis.
American Journal of Anatomy. Bi-m. $7.50 per vol. Philadelphia.
*American Journal of Diseases of Children. M. $4. A. M. A., Chicago.
American Journal of Hygiene. Bi-m. $6. Baltimore.
American Journal of the Medical Sciences. M. $6. Philadelphia.
American Journal of Obstetrics and Gynecology. M. $8.50. St. Louis.
American Journal of Ophthalmology. M. $12. Chicago.
American Journal of Pathology. Bi-m. $5. Boston.
American Journal of Physiology. M. $6 per vol. Baltimore.
American Journal of Psychiatry. Q. $5 per vol. Baltimore.
American Journal of Public Health. M. $5. New York.
American Journal of Roentgenology. M. $10. New York.
American Journal of Surgery. M. $6. New York.
American Journal of Syphilis. Q. $10. St. Louis.
American Journal of Tropical Medicine. Bi-m. $5 per vol. Baltimore.
American Review of Tuberculosis. M. $8 per vol. New York.
Anales de la Facultad de Medicina, Univ. de Montevideo. M. 6 pesos.
*Anales de la Sociedad Mexicana de Oftalmología y Oto-Rino-Laringología. M. $4. Mexico City.
*Annales d'Anatomie Pathologique. M. 65 francs. Paris.
Annales de Dermatologie et de Syphiligraphie. M. 70 francs. Paris.
Annales de l'Institut Pasteur. M. 70 francs. Paris.
Annales des Maladies Vénériennes. M. 70 francs. Paris.
Annales de Médecine. M. 60 francs. Paris.
Annals of Clinical Medicine. M. $7. Baltimore.
Annals of Medical History. Q. $8. New York.
Annals of Otology, Rhinology and Laryngology. Q. $6. St. Louis.
Annals Pickett-Thomson Laboratory. Irreg. £2 2s per vol. London.
Annals of Surgery. M. $10. Philadelphia.
Annals of Tropical Medicine and Parasitology. Irreg. £1 2s. 6d. per vol. Liverpool.
Archiv für Dermatologie und Syphilis. Irreg. Price varies. Berlin.
Archiv für Exper. Pathol. und Pharmakol. Irreg. Leipzig.
Archiv für die Gesamte Physiologie. Irreg. Price varies. Berlin.
Archiv für Gynäkologie. Irreg. Price varies. Berlin.
*Archiv fuer Japanische Chirurgie. Kyoto.
Archiv für Kinderheilkunde. Irreg. 20 gold marks per vol. Stuttgart.
Archiv für Klinische Chirurgie. Irreg. Price varies. Berlin.
Archiv für Ophthalmologie. Irreg. Price varies. Berlin.
Archiv. für Path. Anat. und. Physiol. Irreg. Berlin.
Archiv für Psychiatrie. Irreg. Price varies. Berlin.
Archiv für Schiffs- und Tropenhygiene. M. 25.80 marks. Leipzig.
Archiv für Verdauungs-Krankheiten. Irreg. 28 marks per vol. Berlin.
*Archives of Dermatology and Syphilology. M. $8. A. M. A., Chicago.
Archives of Disease in Childhood. Bi.-m. 25s. London.
Archives Franco-Belges de Chirurgie. M. 80 francs. Brussels.
Archives de l'Institut Pasteur de Tunis. Q. Tunis.
*Archives of Internal Medicine. M. $5. A. M. A., Chicago.
Archives des Maladies de l'Appareil Digestif. M. 65 francs. Paris.
Archives des Maladies du Cœur. M. 60 francs. Paris.
Archives de Médecine des Enfants. M. 60 francs. Paris.
*Archives of Medical Hydrology. Three issues a year. £1 1s. London.
Archives Médicales Belges. M. 30 francs. Brussels.
Archives Médico-Chirurgicales de l'Appareil Respiratoire. Bi-m. 115 francs. Paris.
*Archives of Neurology and Psychiatry. M. $8. A. M. A., Chicago.
Archives d'Ophtalmologie. M. 70 francs. Paris.
Archives of Ophthalmology. Bi-m. $6. New York.
*Archives of Otolaryngology. M. $6. A. M. A., Chicago.
*Archives of Pathology. M. $6. A. M. A., Chicago.
Archives of Physical Therapy, X-Ray, Radium. M. $5. Omaha.
*Archives of Surgery. M. $8. A. M. A., Chicago.
Archivio Italiano di Chirurgia. Irreg. 100 lire per vol. Bologna.
Archivio Italiano di Urologia. Bi-m. 100 lire. Bologna.
Archivio de Patologia e Clinica Medica. Bi-m. 85 lire. Bologna.
*Archivos Argentinos de Enfermedades del Aparato Digestivo. Bi-m. 20 pesetas. Buenos Aires.
*Archivos de Endocrinologia y Nutricion. Bi-m. Madrid.
*Archivos Españoles de Enfermedades del Aparato Digestivo y de la Nutrición. M. 21 pesetas. Madrid.
Archivos Españoles de Pediatria. M. 25 pesetas. Madrid.
Archivos Latino-Americanos de Pediatria. M. $5. Buenos Aires.
*Archivos de Medicina, Cirurgia y Especialidades. W. Madrid.
*Ars Medica. M. 25 pesetas. Barcelona.
Atlantic Medical Journal. M. $3. Harrisburg.
Australian Journal of Experimental Biology. Q. £1 1s. Adelaide.
Beiträge zur Klinik der Tuberk. und Spezifischen Tuberk. Irreg. Berlin.
Beiträge zur klinischen Chirurgie. Irreg. Price varies. Berlin.
Biochemical Journal. Irreg. $14.25. London.
Biochemische Zeitschrift. Irreg. 28 marks per volume. Berlin.
*Boletin del Instituto de Clinica Quirúrgica. Irreg. Buenos Aires.
*Boletin del Instituto de Medicina Experimental. Irreg. Buenos Aires.
*Boletin de la Sociedad de Cirugia de Chile. Irreg. 20 pesos. Santiago.
*Boletin de la Sociedad de Cirugia de Guadalajara. M.
*Boletin de la Sociedad de Obstetricia de Buenos Aires. Irreg. $5 per vol.
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Am.—*American* *Med.*—*Medicine*
A.—*Association* *Nat.*—*National*
Coll.—*College* *Phar.*—*Pharmaceutical*
Conf.—*Conference* *Phys.*—*Physicians*
Cong.—*Congress* *Ry.*—*Railway*
Conv.—*Convention* *S.*—*Surgical*
Dist.—*District* *Soc.*—*Society*
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